TOBACCO, ALCOHOL, & OTHER DRUG ABUSE TRENDS IN WASHINGTON STATE

2002 Report

THE DIVISION OF
Alcohol & Substance Abuse

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Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State,

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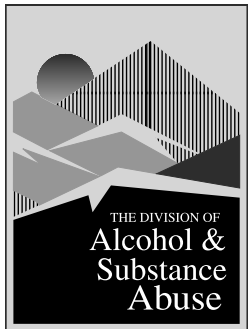
2002 Report



David H. Albert

September 2002

Kenneth D. Stark, Director
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GARY LOCKE
Governor

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Message from the Governor

September 2002

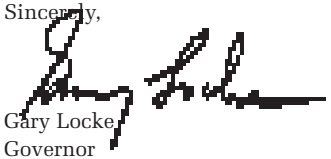
It is my pleasure to share with you the 2002 edition of *Tobacco, Alcohol and Other Drug Abuse Trends in Washington*.

Chemical addiction places a heavy toll on communities throughout Washington. It not only devastates individuals and their families, but also is linked to increased violence, crime and delinquency; academic decline among our students; and often is a factor in birth defects, automobile accidents, and serious illnesses. On a broader scale, this societal problem threatens our state's economic vitality.

In these challenging times, government leaders are being called upon to make hard budgetary decisions and redouble their efforts to make the best possible use of limited resources. As this report indicates, making investments in quality drug prevention, intervention and treatment services is one of the most effective ways to protect public health.

The availability of reliable and comprehensive data is essential to good descision-making at both the state and local level. This publication is a valuable tool in our continuous efforts to eradicate substance abuse among youth and adults in Washington. Together, I know we can help our citizens lead healthier, more productive lives.

Sincerely,



Gary Locke
Governor

Message from the Director

2002 marks the publication of the 10th anniversary edition of *Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State*. Earlier Trends reports dating back to 1993 were published in an effort to document and monitor Washington State's progress towards meeting the national ***Healthy People 2000*** goals established by the U.S. Department of Health and Human Services. A new report ***Healthy People 2010*** has now been published, and provides statistical milestones by which health care policymakers and analysts can measure progress in the prevention of disease and disability. The *Trends 2002 Report* makes use of the new target objectives and data included in ***Healthy People 2010.***

In these lean economic times, the *2002 Trends Report* demonstrates that the provision of quality substance abuse prevention and treatment services represents an opportunity to impact individuals, families, communities, and our state budget. A study completed last year by the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated that in 1998, Washington State government spent $1.5 billion on the consequences of substance abuse, representing 10% of the total state budget. These expenditures were 40% more than the transportation budget for the same year. Only 4% of the $1.5 billion was spent on prevention and treatment. The remainder was spent on the consequences of substance abuse, representing a cost of $248 for every state resident.

Data included in ten consecutive *Trends* reports prove beyond a shadow of a doubt that treatment works. Treatment for adolescents reduces school discipline problems, delinquent behavior, involvement in the juvenile justice system, and improves school performance. Treatment for pregnant women reduces the number of low birth weight babies, pre-term deliveries, fetal and infant deaths, and medical costs during the first two years of a child's life. Low-income patients who receive chemical dependency treatment are less likely to require welfare assistance, are more likely to gain employment, have higher wages, utilize fewer medical and psychiatric services, and are arrested less frequently. Drivers accused of Driving Under the Influence are less likely to have a second offense following treatment.

Yet, we are still faced with the reality that 15 out of every 20 adults who are in need of and qualify for publicly funded treatment do not receive it. In addition, many Washington youth are still initiating use of alcohol, tobacco, and other drugs at a very young age. For too many, this use progresses to dependency and addiction. To effect positive change, the funding equation whereby we pay for the consequences of chemical dependency rather than investing in the health and well-being of our citizens and communities will have to be altered in a major way.

With our community partners in the prevention and treatment fields, DASA stands committed to a healthier Washington. We look forward to the challenges of joining with others to ensure our citizens are well-equipped to live happier, more productive lives in communities free of the devastation wrought by alcohol, tobacco, and drug abuse.

Kenneth D. Stark

[1]National Center on Addiction and Substance Abuse at Columbia University. (2001). Shoveling up: The impact of substance abuse on state budgets. New York. NY.

In 2001, the Division of Alcohol and Substance Abuse (DASA), with the assistance of the Citizens Advisory Council on Alcoholism and Drug Addiction and others, adopted a new Strategic Plan for 2001-2006. In doing so, DASA revisited and revised its Mission Statement to reflect the needs of Washington residents and the philosophy behind the operations of the Division as we enter the 21st Century.

Mission

The Mission of the Department of Social and Health Services is to improve the quality of life for individuals and families in need. We will help people to achieve safe, self-sufficient, healthy and secure lives. The Division of Alcohol and Substance Abuse promotes strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency.

To succeed in its Mission, the Division of Alcohol and Substance Abuse is dedicated to building collaborative partnerships with communities, tribes, counties, service providers, schools, colleges and universities, the criminal justice system, and other agencies within the private sector and within local, state and federal governments. The Division is committed to ensuring services are provided to individuals and communities in ways that are culturally relevant, and honor the diversity of Washington State.

To carry forth our Mission, the Division of Alcohol and Substance Abuse will:

- Develop policy options, and plan for the development and delivery of an effective continuum of chemical dependency prevention and treatment services.
- Provide and ensure quality services that support individuals and families in their efforts to raise children who are free of alcohol, tobacco, and other drugs.
- Educate communities about the importance of maintaining healthy lifestyles, and provide opportunities, tools and resources to enable communities to define and meet their local substance abuse prevention needs.
- Implement a continuum of intervention and treatment services to meet local, regional, tribal and statewide needs, and which specifically address the needs of low-income adults, youth, women, children, and families.
- Support continued recovery and a return to competitive employment by helping individuals surmount barriers to self-sufficiency.

- Develop standards, and assist providers in attaining, maintaining, and improving the quality of care for individuals and families in need of prevention and treatment services.
- Provide training and professional development opportunities for the chemical dependency field.
- Oversee and coordinate research that identifies need for publicly funded services, and assesses prevention and treatment
- Provide management information services and support to internal and external customers.
- Manage available resources in a manner consistent with sound business practices.
- Advocate for the enhanced availability of, and resources for, prevention and treatment services as a primary avenue for protecting and promoting the public health and safety of all Washington residents.

Strategic Goals

As part of its Strategic Plan and to serve its broader mission, DASA has set eight strategic goals for 2001-2006:

- Protect vulnerable adults, children, and families;
- Break down barriers to self-sufficiency;
- Assure public safety and help build strong, healthy communities;
- Reduce misuse and improve lives through preventive action;
- Promote accountability and public stewardship in policy, programs and practice;
- Improve quality through innovation, technology and research;
- Build a strong, committed workforce.

The Division of Alcohol and Substance Abuse (DASA) first published the *Tobacco, Alcohol, and Other Drug Abuse Trends Report* in 1993 as an effort to document and monitor Washington State's progress towards the ***Healthy People 2000: National Health Promotion and Disease Prevention Objectives***. Published in 1990, ***Healthy People 2000*** provided statistical milestones by which health policy makers and analysts can measure progress in the prevention of morbidity and mortality. A successor – ***Healthy People 2010*** – published by the U.S. Department of Health and Human Services, sets new objectives for the current decade.

Healthy People 2000 noted the significant impact that alcohol, tobacco, and other drugs have on the health of individuals and communities:

> Recognition and acknowledgement of the gravity of alcohol and other drug problems in the United States are changing the social climate. Almost every national opinion poll places alcohol and other drug problems as a priority concern, and the national effort to prevent these problems have mobilized government, schools, communities, businesses, and families...Progress will depend greatly upon increasing levels of education and awareness.[1]

Public education and awareness are integral parts of DASA's goal – to reduce the likelihood of individuals becoming chemically dependent, and to provide an opportunity for chemically dependent persons to achieve and maintain recovery. This *Report* represents an important tool in our ongoing efforts towards this goal.

We continue to expand and refine the *Report*. This year, we have added new information on the actual impact of substance abuse on state government spending and on school performance, and on the relationship between alcohol and drug abuse and child abuse and corrections. There is a new section on treatment completion. In addition, there are reports of new outcome studies on cost offsets achieved by providing chemical dependency treatment to Supplemental Security Insurance recipients, and through the treatment of mentally ill substance-abusing patients. There is also information gained through DASA's new client satisfaction survey. Finally, there are two new essays on policy issues confronting Washington State. They are:

- From Research to Practice
- Treatment Retention and Completion.

[1] U.S. Public Health Service. (1990). Healthy people 2000: National health promotion and disease prevention objectives (pp. 164-165). Washington, DC: U.S. Department of Health and Human Services.

The federal Controlled Substance Act (CSA) of 1970 gave Congress the authority to regulate the interstate commerce of drugs, and established five schedules that classify all substances, which were in some manner regulated under existing federal law. The placement of each drug is based upon the substance's medical use, potential for abuse, safety, and risk of dependence. The Act also provides a mechanism for substances to be controlled, or added to a schedule; decontrolled, or removed from control; and rescheduled or transferred from one schedule to another.

In determining into which schedule a drug or other substance should be placed, or whether a substance should be decontrolled or rescheduled, certain factors are required to be considered as follows:

- The drug's actual or relative potential for abuse;
- Scientific evidence of the drug's pharmacological effects;
- The state of current scientific knowledge regarding the substance;
- Its history and current pattern of abuse;
- The scope, duration, and significance of abuse;
- What, if any, risk there is to the public health;
- The drug's psychic or physiological dependence liability;
- Whether the substance is an immediate precursor of a substance already controlled.

Schedule I

- The drug or other substance has a high potential for abuse.
- The drug or other substance has no currently accepted medical use in treatment in the United States.
- There is a lack of accepted safety for use of the drug or other substance under medical supervision.
- Some Schedule I substances are heroin, LSD, marijuana, and methaqualone.

Schedule II

- The drug or other substance has a high potential for abuse.
- The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
- Abuse of the drug or other substance may lead to severe psychological or physical dependence.
- Schedule II substances include morphine, PCP, cocaine, methadone, and methamphetamine.

Schedule III

- The drug or other substance has a potential for abuse less than the drugs or other substances in Schedules I and II.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.
- Anabolic steroids, codeine and hydrocodone with aspirin or Tylenol, and some barbiturates are Schedule III substances.

Schedule IV

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.
- Included in Schedule IV are Darvon, Talwin, Equanil, Valium and Xanax.

Schedule V

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule IV.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.
- Over-the-counter cough medicines with codeine are classified in Schedule V.

Controlled Substances Uses & Effects

Drugs	CSA Schedules	Trade or Other Names	Medical Uses
NARCOTICS			
Heroin	I	Diacetylmorphine, Horse, Smack	None in U.S., Analgesic, Antitussive
Morphine	II	Duramorph, MS-Contin, Oramorph SR, Roxanol	Analgesic
Codeine	II, III, V	Empirin w/Codeine, Fiorinal w/Codeine, Robitussin A-C, Tylenol w/Codeine	Analgesic, Antitussive
Hydrocodone	II, III	Lorcet, Hycodan, Tussionex, Vicodin	Analgesic, Antitussive
Hydromorphone	II	Dilaudid	Analgesic
Oxycodone	II	Percocet, Percodan, Roxicet, Roxidodone, Tylox	Analgesic
Methadone and LAAM	I, II	Dolophine, levomethadyl acetate, Orlaam	Analgesic, Treatment of Dependence
Fentanyl and Analogs	I, II	Alfenta, Duragesic, Innovar, Sufenta	Analgesic, Anesthetic
Other Narcotics	II, III, IV, V	Buprenex, Darvon, Demerol, opium, Talwin	Analgesic, Antidiarrheal
DEPRESSANTS			
Chloral Hydrate	IV	Noctec, Somnos, Felsules	Hypnotic
Barbiturates	II, III, IV	Amytal, Florinal, Nembutal, Seconal, Tuinal	Anesthetic, Anticonvulsant, Sedative, Hypnotic, Veterinary Euthanasia Agent
Benzodiazepines	IV	Ativan, Dalmane, Diazepam, Halcion, Librium, Paxipam, Rohypnol[2], Serax, Tranxene, Valium, Versed, Xanax	Antianxiety, Sedative, Anticonvulsant, Hypnotic
Glutethimide	II	Doriden	Sedative, Hypnotic
Gamma Hydroxybutyrate[1]	I	GHB, Georgia Home Boy, Liquid Ecstasy	None in U.S.
Other Depressants	I, II, III, IV	Equanil, Miltown, Noludar, Placidyl, Valmid	Antianxiety, Sedative, Hypnotic

Source: U.S. Department of Justice, Drug Enforcement Administration

[1] Washington State Board of Pharmacy has GHB and related analogs scheduled in catagory III.
[2] Some of the following drug names are products that may contain other active agents.

Physical Dependence	Psychological Dependence	Tolerance	Duration (Hours)	Usual Method	Possible Effects	Effects of Overdose	Withdrawal Syndrome
NARCOTICS							
High	High	Yes	3 - 6	Injected, Sniffed, Smoked	• Euphoria • Drowsiness • Respiratory depression • Constricted pupils • Nausea	• Slow & shallow breathing • Clammy skin • Convulsions • Coma • Possible death	• Watery eyes • Runny nose • Yawning • Loss of appetite • Irritability • Tremors • Panic • Cramps • Nausea • Chills & sweating
High	High	Yes	3 - 6	Oral, Smoked, Injected			
Moderate	Moderate	Yes	3 - 6	Oral, Injected			
High	High	Yes	3 - 6	Oral			
High	High	Yes	3 - 6	Oral, Injected			
High	High	Yes	4 - 5	Oral			
High	High	Yes	12 - 72	Oral, Injected			
High	High	Yes	.10 - 72	Injected, Trans-dermal Patch			
High-Low	High-Low	Yes	Variable	Oral, Injected			
DEPRESSANTS							
Moderate	Moderate	Yes	5 - 8	Oral	• Slurred speech • Disorientation • Drunken behavior without odor of alcohol	• Shallow respiration • Clammy skin • Dilated pupils • Weak & rapid pulse • Coma • Possible death	• Anxiety • Insomnia • Tremors • Delirium • Convulsions • Possible death
High-Mod.	High-Mod.	Yes	1 - 16	Oral, Injected			
Low	Low	Yes	4 - 8	Oral, Injected			
High	Moderate	Yes	4 - 8	Oral			
Unknown	Unknown	Yes	Dependent on dose	Oral, Snorted			
Moderate	Moderate	Yes	4 - 8	Oral			

Controlled Substances Uses & Effects

Drugs	CSA Schedules	Trade or Other Names	Medical Uses
STIMULANTS			
Cocaine	II	Coke, Flake, Snow, Crack	Local anesthetic
Amphetamine/Methamphetamine	II	Adderall, Desoxyn, Dexedrine	Attention deficit disorder, narcolepsy, weight control
Methylphenidate	II	Ritalin	Attention deficit disorder, narcolepsy
Other Stimulants	II, III, IV	Adipex, Didrex, Ionamin, Melfiat, Meridia, Plegine, Prelu-2, Preludin, Sanorex, Tenuate, Tepanil	Weight control
CANNABIS			
Marijuana	I	Acapulco Gold, Grass, Mary Jane, Pot, Reefer, Sinsemilla, Thai Sticks	None
Tetrahydrocannabinol	I, II	Marinol, THC	Antinauseant
Hashish and Hashish Oil	I	Hash, Hash Oil	None
HALLUCINOGENS			
LSD	I	Acid, Boomers, Microdot, Trips	None
Mescaline & Peyote	I	Buttons, Cactus, Mescal	None
Amphetamine Variants	I	DOM, DOB, Ecstasy, MDA, MDMA, Nexus, STP	None
Phencyclidine & Analogs	I, II	Angel Dust, Hog, Loveboat, PCE, PCP, TCP	None
Ketamine	III	Ketaject, Ketalar	General anesthetic
Other Hallucinogens	I	Bufotenine, DMT, Ibogaine, Psilocybin, Psilocyn	None
ANABOLIC STEROIDS			
Testosterone (Cypionate, Enanthate)	III	Androderm, Delatestryl, Depo-Testosterone	Hypogonadism
Nandrolone (Decanoate, Phenpropionate)	III	Deca-Durabolin, Durabolin, Nortestonsterone	Anemia, Breast cancer
Oxymetholone	III	Anadrol-50	Anemia

Source: U.S. Department of Justice, Drug Enforcement Administration; National Institute on Drug Abuse

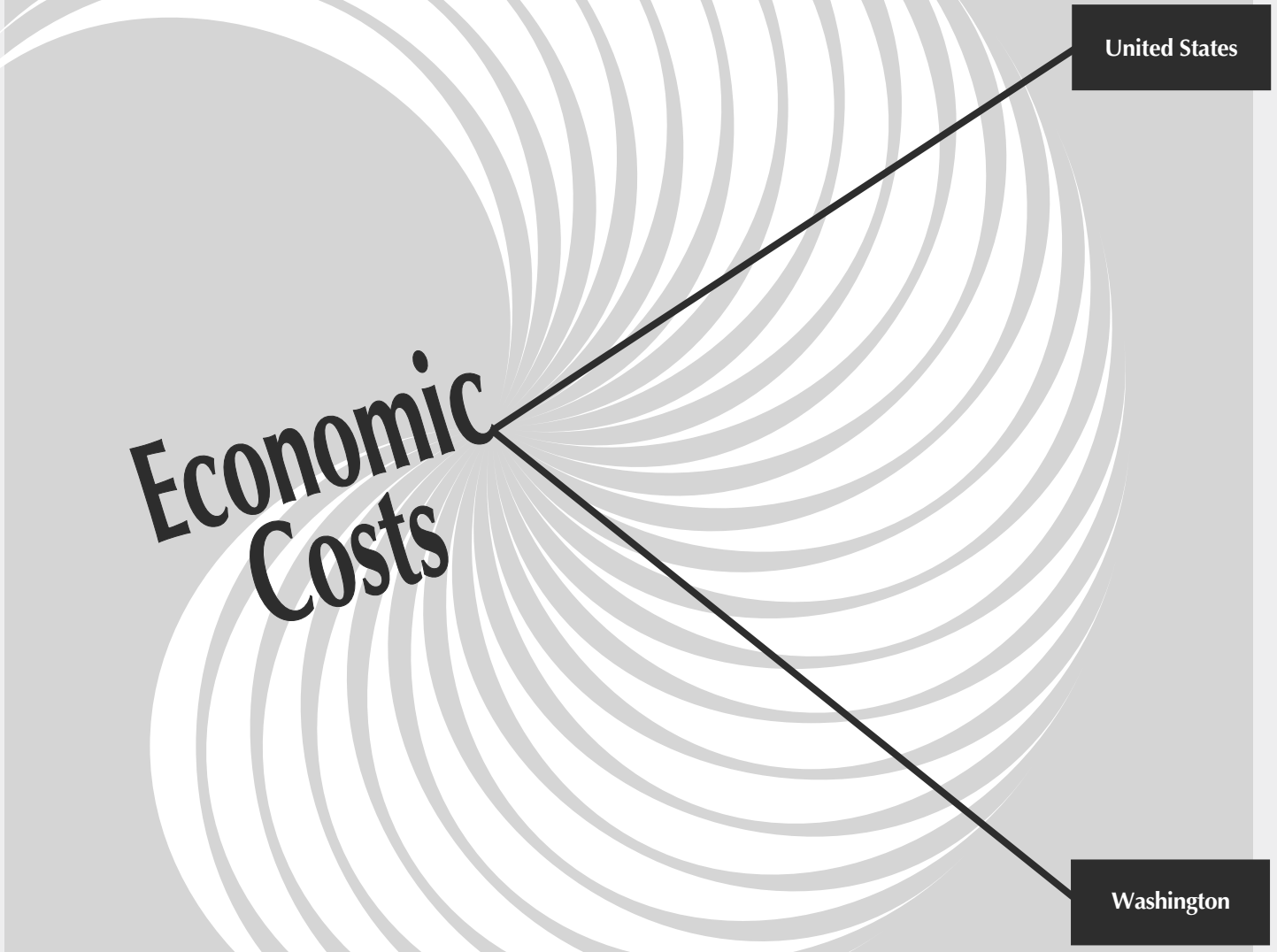
Physical Dependence	Psychological Dependence	Tolerance	Duration (Hours)	Usual Method	Possible Effects	Effects of Overdose	Withdrawal Syndrome
STIMULANTS							
Possible	High	Yes	1 - 2	Sniffed, Smoked, Injected	• Increased alertness • Excitation • Euphoria • Increased pulse rate & blood pressure • Insomnia • Loss of appetite	• Agitation • Increased body temperature • Hallucinations • Convulsions • Possible death	• Apathy • Long periods of sleep • Irritability • Depression • Disorientation
Possible	High	Yes	2 - 4	Oral, Injected, Smoked			
Possible	High	Yes	2 - 4	Oral, Injected			
Possible	High	Yes	2 - 4	Oral, Injected			
CANNABIS							
Unknown	Moderate	Yes	2 - 4	Smoked, Oral	• Euphoria • Relaxed inhibitions • Increased appetite • Disorientation	• Fatigue • Paranoia • Possible psychosis	• Occasional reports of insomnia • Hyperactivity • Decreased appetite
Unknown	Moderate	Yes	2 - 4	Smoked, Oral			
Unknown	Moderate	Yes	2 - 4	Smoked, Oral			
HALLUCINOGENS							
None	Unknown	Yes	8 - 12	Oral	• Illusions and hallucinations • Altered perception of time and distance	• Longer • More intense "trip" episodes • Psychosis • Possible death	• Unknown
None	Unknown	Yes	8 - 12	Oral			
Unknown	Unknown	Yes	Variable	Oral, Injected			
Unknown	High	Yes	Days	Oral, Smoked			
Unknown	Unknown	Yes	Variable	Injected, Oral, Smoked			
None	Unknown	Possible	Variable	Smoked, Oral, Injected, Sniffed			
ANABOLIC STEROIDS							
Unknown	Unknown	Unknown	14 - 28 Days	Injected	• Virilization • Acne • Testicular atrophy • Gynecomastia • Agressive behavior • Edema	• Unknown	• Possible depression
Unknown	Unknown	Unknown	14 - 21 Days	Injected			
Unknown	Unknown	Unknown	24	Oral			

How Washington State Compares With The Nation On Current Health Indicators

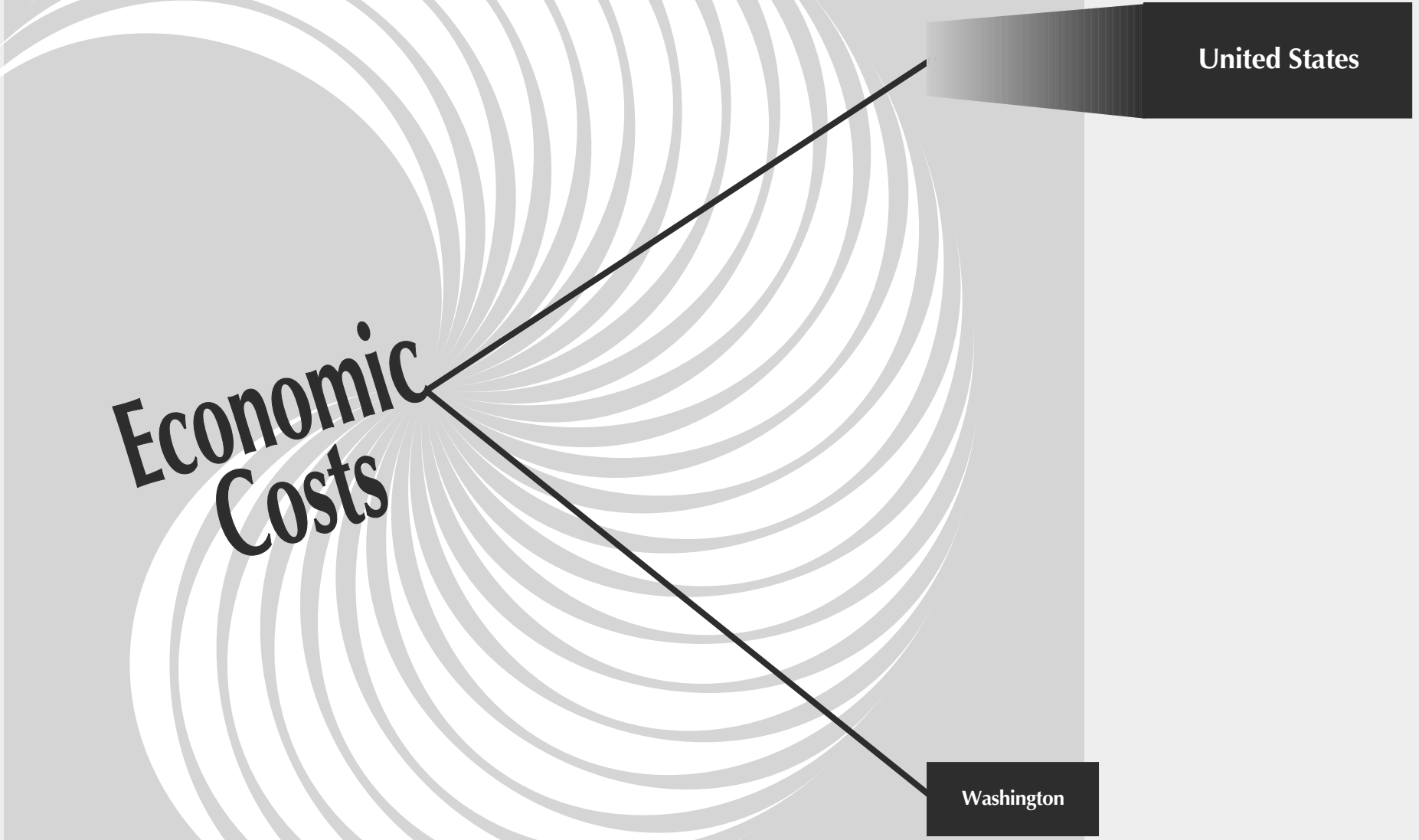
Below is a summary of comparisons between Washington State and the nation on the substance use indicators in this year's report. While this summary shows that Washington State appears to be ahead of the nation on many of the indicators (that is, closer to the **Healthy People 2010** objectives), it is important to remember that there is still much room for improvement in the state's efforts to reduce and prevent the tragic consequences of tobacco, alcohol, and other drug use.

Washington State Appears the Same or Better than the Nation in:	Washington State Appears Worse than the Nation in:
Recent Use by 8th, 10th, and 12th Grade Students - Cigarettes	8th, 10th and 12th Grade Students Who Ever Used - Cigarettes
Recent Use by 12th Grade Students - Alcohol	8th, 10th and 12th Grade Students Who Ever Used - Alcohol
Use of Anabolic Steroids by Male High School Seniors	8th, 10th and 12th Grade Students Who Ever Used - Marijuana
Adult Smoking Rates	Recent Use by 8th and 10th Grade Students - Alcohol
Per Capita Alcohol Consumption	Recent Use by 8th, 10th, and 12th Grade Students - Marijuana
Low Birth Weight Babies	Heavy Drinking by 8th, 10th and 12th Grade Students
Infant Mortality	Perception of Harm by 8th, 10th and 12th Grade Students - Heavy Alcohol Use
Alcohol-Related Traffic Fatalities	Perception of Harm by 8th, 10th and 12th Grade Students - Occasional Marijuana Use
Residential Fire Deaths	Lung Cancer Deaths
Liver Cirrhosis Deaths	Drowning Deaths
Deaths from Coronary Heart Disease	Drug-Related Deaths
Hospital Discharges for Alcohol-Related Morbidity	Deaths From Chronic Lower Repiratory Disease
AIDS Case Rate	Drug-Related Emergency Department Visits
Tuberculosis Case Rate	Alcohol-Related Deaths
Hepatitis B Case Rate	Property Crime Index
Syphilis Infection Rate	Suicide Deaths
Gonorrhea Infection Rate	Divorce Rate
Drug Abuse Violation Arrests	DUI Arrests
Prostitution Arrests	
Homicide Deaths	
Aggravated Assault Arrests	
Violent Crime Index	
Teen Birth Rate	

The Economic Costs of Substance Abuse



The Economic Costs of Substance Abuse



The Economic Costs of Substance Abuse in the United States

A study sponsored by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism estimated the total economic costs of alcohol and drug abuse in the United States at more than $276 billion in 1995.[1]

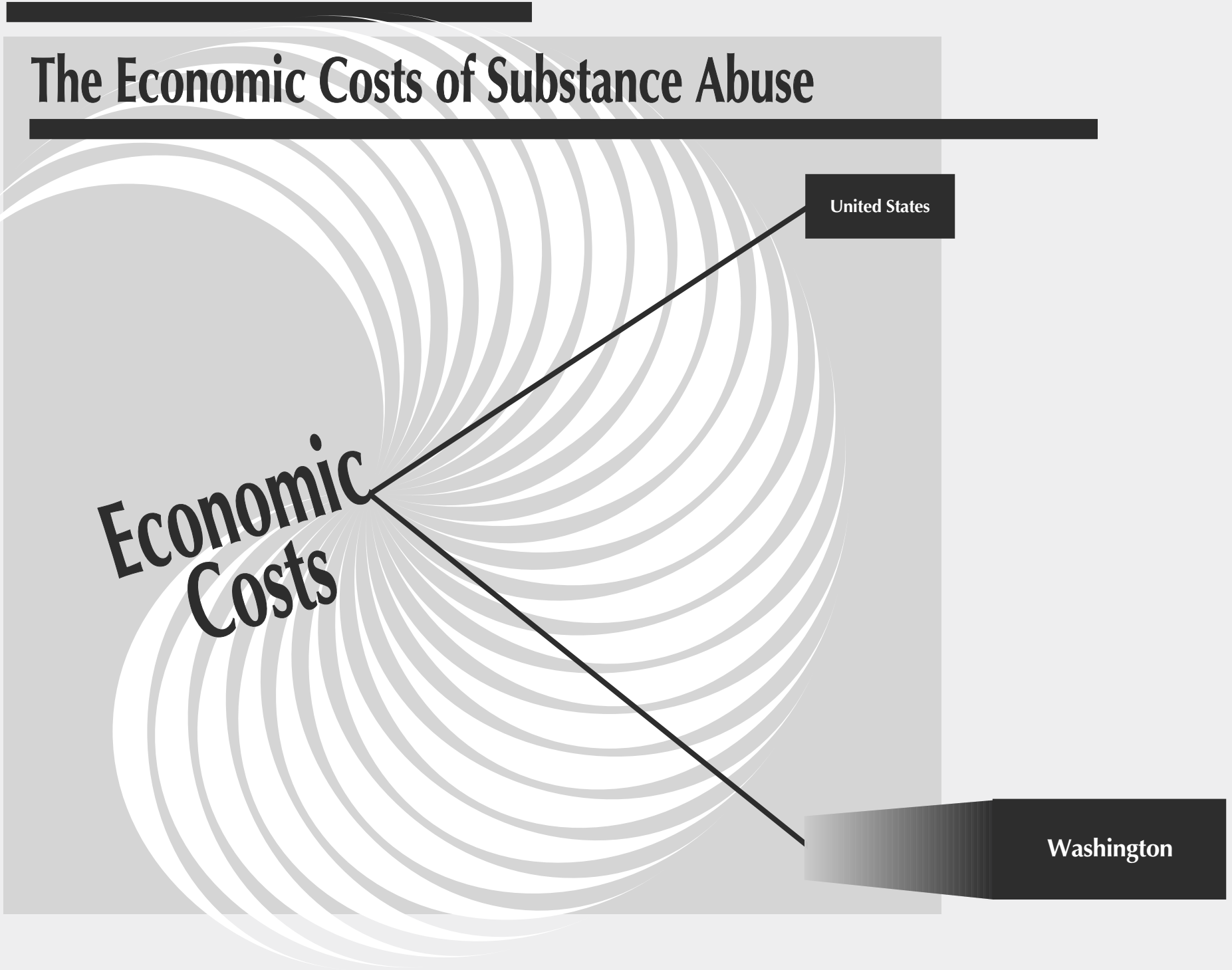
Among the study's key findings were:

- *Alcohol abuse accounted for 60% of the total economic costs; 40% were attributable to drug abuse.*
- *More than 132,000 deaths were attributable to substance abuse.*
- *Lost earnings due to premature death, illness, disability, crime, and victimization constituted 71% of the total costs.*
- *Total medical costs related to alcohol and drug abuse ($22.5 billion) were approximately double the amount spent on treatment ($11.9 billion).*
- *Medical costs related to alcohol abuse ($15.8 billion) were almost two-and-a-half times those for drug abuse ($6.6 billion).*
- *Less than 4.3% of total economic costs were for treatment.*

A 2000 study found that, of the more than $1.05 trillion spent on health care in the United States in 1997, less than 1% ($11.4 billion) went for substance abuse treatment.[2]

[1]Harwood, Henrick, Fountain, Douglas, and Livermore, Gina. (1998). The economic costs of alcohol and drug abuse in the United States – 1992, Table 1.4. Bethesda, MD: U.S. Department of Health and Human Services.
[2]Coffey, R., Mark, T., King, E., Harwood, H., McKusick, D., Genuardi, J., Dilonardo, H., and Buck, J. (2000). National expenditures for mental health and substance abuse treatment, 1997. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment and Center for Mental Health Services.

The Economic Costs of Substance Abuse



The Economic Costs of Substance Abuse in the Washington State

A recent study sponsored by the Division of Alcohol and Substance Abuse estimated the total economic costs of alcohol and drug abuse in Washington State at $2.54 billion in 1996.[1] This represents approximately $531 for every non-institutionalized resident in the state.

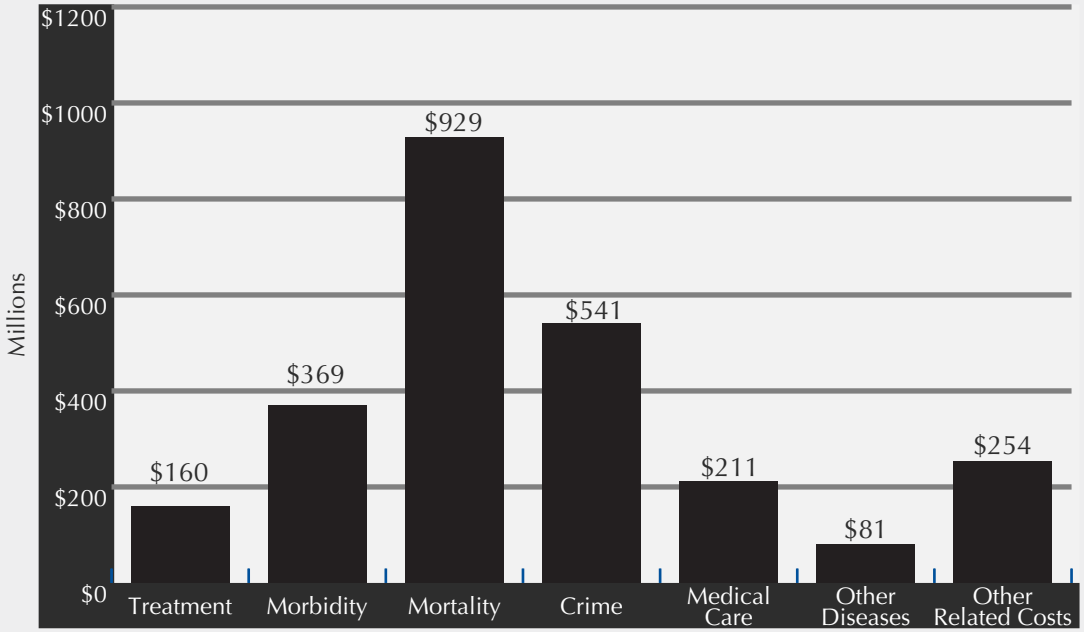
Among the study's key findings were:

- *59% of the economic costs were attributable to the use of alcohol; 41% to the use of drugs.*
- *There were 2,824 deaths in 1996 caused by or related to alcohol or drug abuse, representing approximately 70,000 years of potential lives lost.*
- *Of the 2,824 deaths, 2,318 were alcohol-related, and 506 were drug-related.*
- *Leading causes of substance abuse-related deaths were motor vehicle accidents (353 deaths), alcohol cirrhosis (291 deaths), and suicide (223 deaths).*
- *Of 217 arrests for homicide, 65 were alcohol-related, and 22 were drug-related.*
- *Of 6,003 arrests for felonious assault, 1,801 were alcohol-related, and 144 were drug-related.*
- *There were 16,000 hospital discharges classified as alcohol- or drug-related.*
- *Total estimated alcohol- and drug-related crime costs in 1996 rose to $541 million from $348 million in 1990, representing a 55% increase.*

[1]Wickizer, T. (1999). The economic costs of drug and alcohol abuse in Washington State, 1996. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

Costs Related to Mortality, Crime, and Morbidity Represent the Largest Economic Costs of Drug and Alcohol Abuse.

Economic Costs of Drug and Alcohol Abuse in Washington, 1996



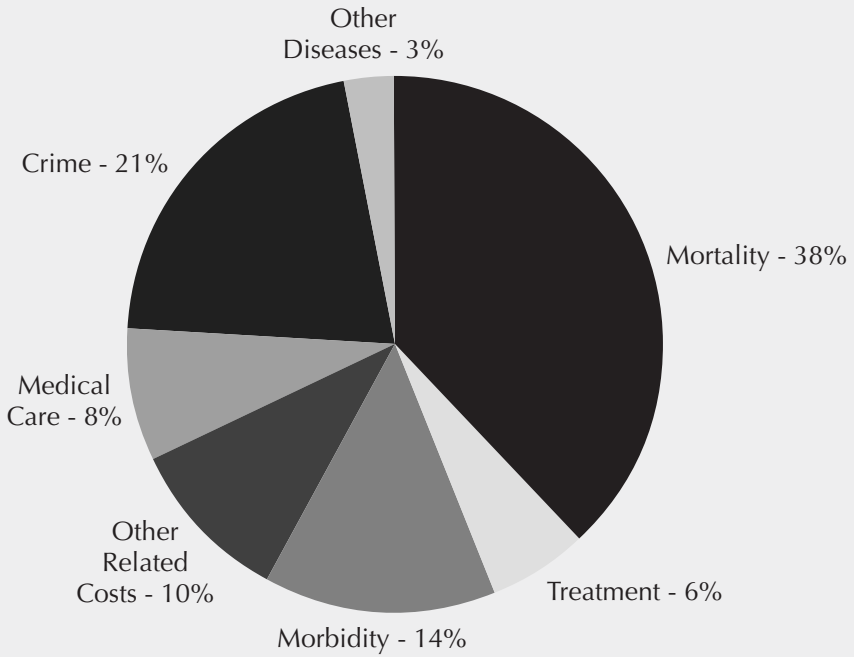
Source: Wickizer, T. (1999). The economic costs of drug and alcohol abuse in Washington State, 1996. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

This graph indicates that mortality-, crime-, and morbidity-related costs represented the largest economic costs of substance abuse in 1996. The estimated cost per death measured in terms of lost income was $329,000. The number of inmates in state prisons for both alcohol- and drug-related crimes rose significantly from 1990 to 1996: from 658 to 1,429 (representing a 117% increase) for alcohol, and from 1,692 to 3,637 (representing a 115% increase) for drugs.[1]

[1]Wickizer, T. (1999). The economic costs of drug and alcohol abuse in Washington State, 1996. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

Treatment Represented Only 6% of the Total Economic Costs of Alcohol and Drug Abuse in 1996.

Distribution of Drug and Alcohol Costs



Source: Wickizer, T. (1999). The economic costs of drug and alcohol abuse in Washington State, 1996. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

This chart indicates that alcohol and drug treatment represents a very small fraction of the total economic costs of substance abuse in Washington State.[1] Yet, data — much of which is contained in this report — indicate that treatment can contribute significantly to lower morbidity and mortality, decreased crime, increased employment and higher worker productivity, reduced spread of infections diseases, and lower medical costs. Alcohol and drug treatment continue to be wise investments in the health and safety of communities, and the economic vitality of Washington State.

[1]Wickizer, T. (1999). The economic costs of drug and alcohol abuse in Washington State, 1996. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

Impacts of Substance Abuse on the Washington State Budget

A 2001 study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated 1998 state government spending on the consequences of substance abuse in Washington State at $1.5 billion. Only 4% of that total was spent on prevention and treatment.[1]

Other key findings of the study included:

- *Nationally, of a total of $620 billion in state government spending, $81.3 billion (13.1%) was used to deal with substance abuse and addiction.*

- *Of every such dollar spent by states, 96 cents went to "shoveling up the wreckage of substance abuse and addiction"; only four cents was used to prevent and treat it.*

- *Combined, states spent 113 times as much to deal with the devastation substance abuse and addiction wrought upon children as they did to prevent and treat it.*

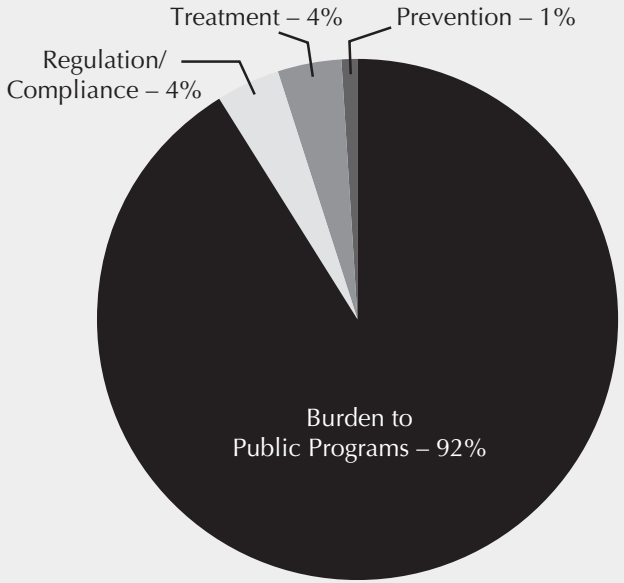
- *Of the $25 billion spent on dealing with the impacts of substance abuse on children, $16.5 billion was borne by the public education system; another $5.3 billion was spent on services for children who were victims of substance abuse and neglect; and almost $3 billion was spent serving substance-involved youth in states' juvenile justice systems.*

- *Each American paid $277 per year in state taxes to deal with the burden of substance abuse and addiction within social programs, and only $10 for prevention and treatment.*

[1] National Center on Addiction and Substance Abuse at Columbia University. (2001). Shoveling up: The impact of substance abuse on state budgets. New York. NY.

Of the $13.9 Billion in Washington State Government Spending in 1998, $1.5 Billion (10.9%) was Spent on Services Related to Impacts of Substance Abuse.

Distribution of State Spending Related to Impacts of Substance Abuse

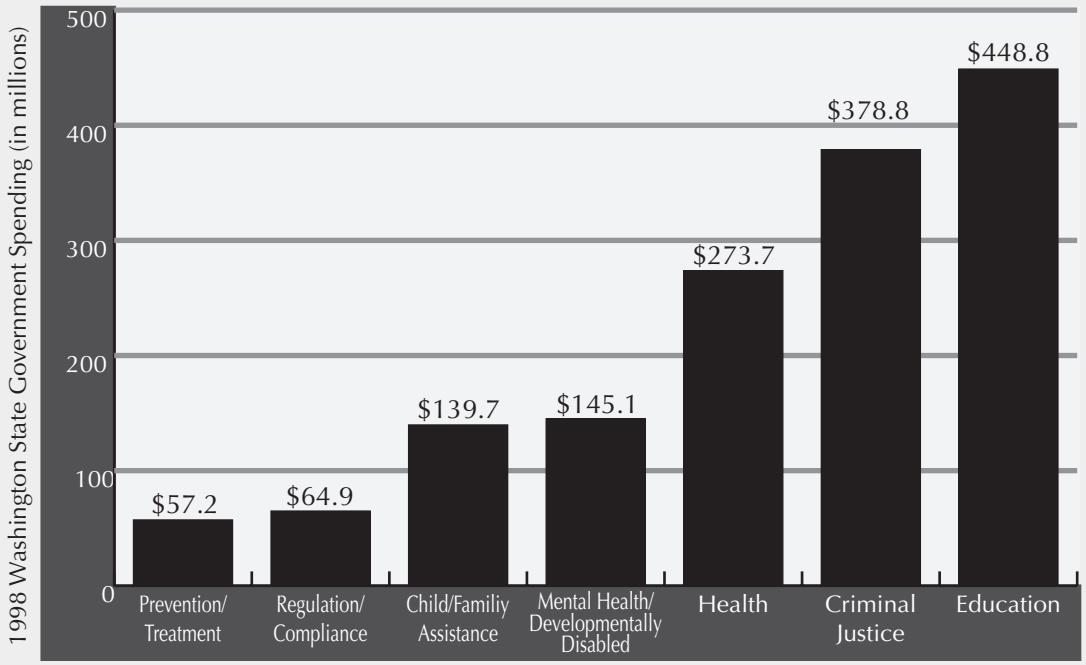


Source: National Center on Addiction and Substance Abuse at Columbia University (2001). Shoveling Up: The Impact of Substance Abuse on State Budgets.

In 1998, the $1.51 billion of Washington State government spending related to the impacts of substance abuse compares with $2.65 billion spent on higher education, $1.46 billion spent on Medicaid, and $1.09 billion spent on transportation.[1]

[1] National Center on Addiction and Substance Abuse at Columbia University. (2001). Shoveling up: The impact of substance abuse on state budgets. New York. NY.

Substance Abuse Results in Significantly Higher State Government Spending on Education, Criminal Justice, and Health.

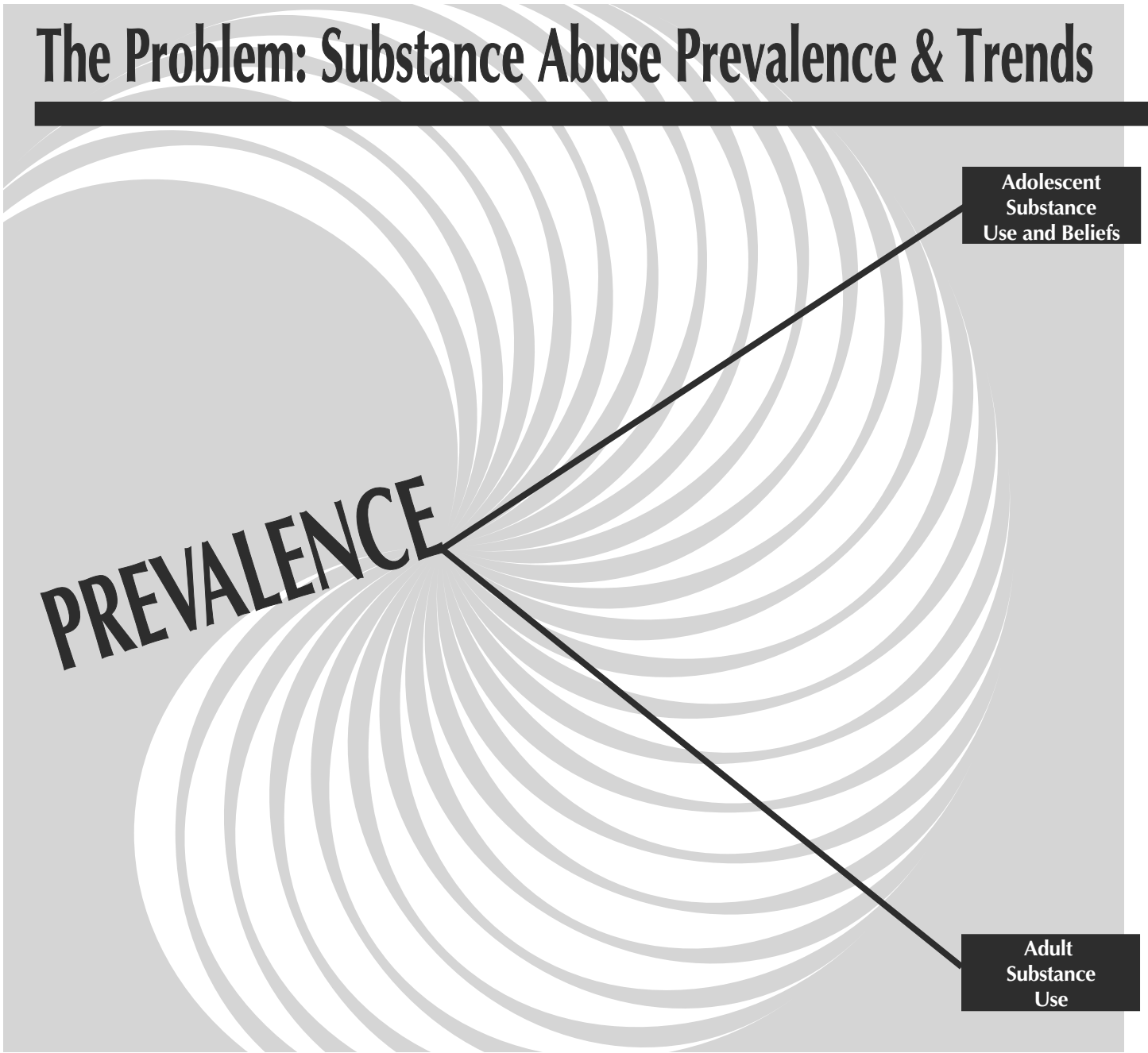


Source: National Center on Addiction and Substance Abuse at Columbia University (2001). Shoveling Up: The Impact of Substance Abuse on State Budgets.

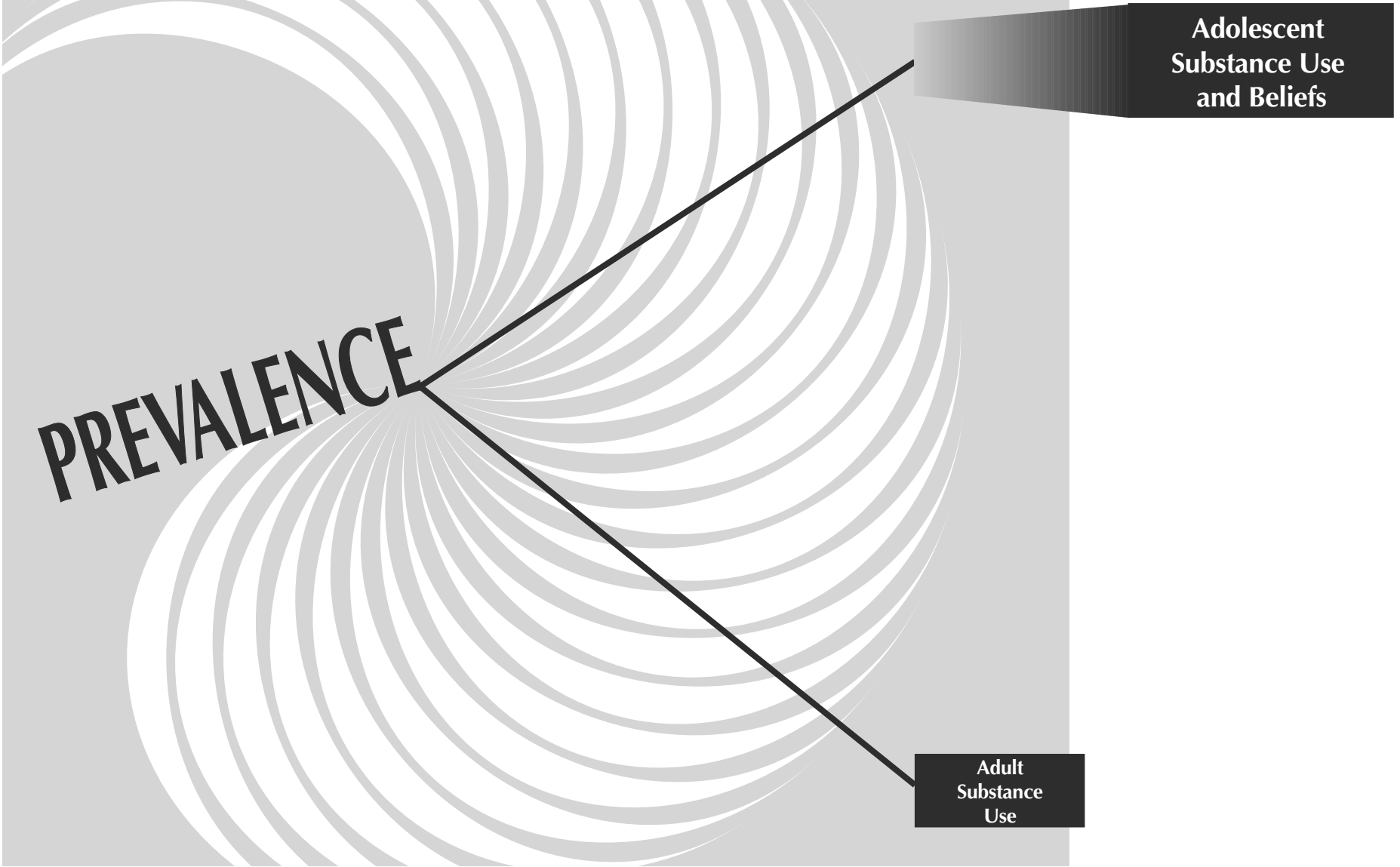
In 1998, 10% of Washington State government spending, or $248 for every resident, was related to impacts of substance abuse. Only approximately $10 of this amount went for prevention and treatment. [1]

[1] National Center on Addiction and Substance Abuse at Columbia University. (2001). Shoveling up: The impact of substance abuse on state budgets. New York. NY.

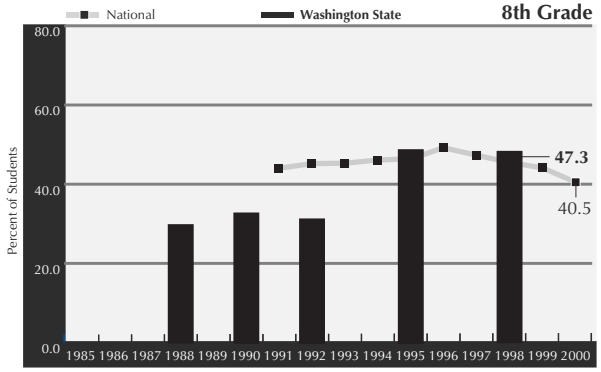
The Problem: Substance Abuse Prevalence & Trends

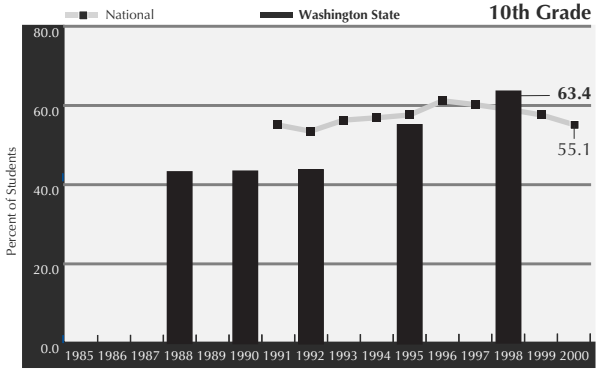


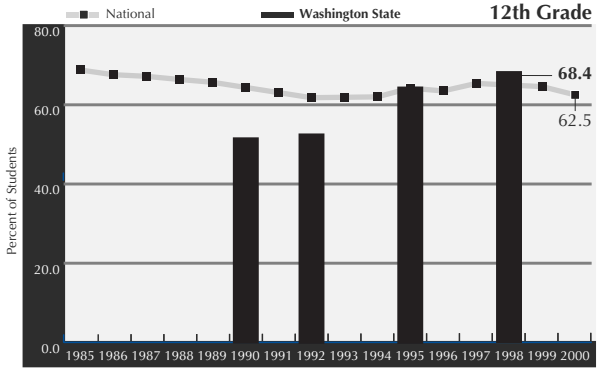
The Problem: Substance Abuse Prevalence & Trends



In 1998, Washington State Students in Grades 8, 10, and 12 were More Likely to Have Ever Smoked a Cigarette than Their Counterparts Nationally. *







These graphs indicate that, in 1998, a lower percentage of Washington State students in grades 8, 10, and 12 were likely to have tried smoking than their counterparts nationally. ***Healthy People 2010*** sets a target objective to increase the average age of adolescents' first use of tobacco products from 12 to 14.

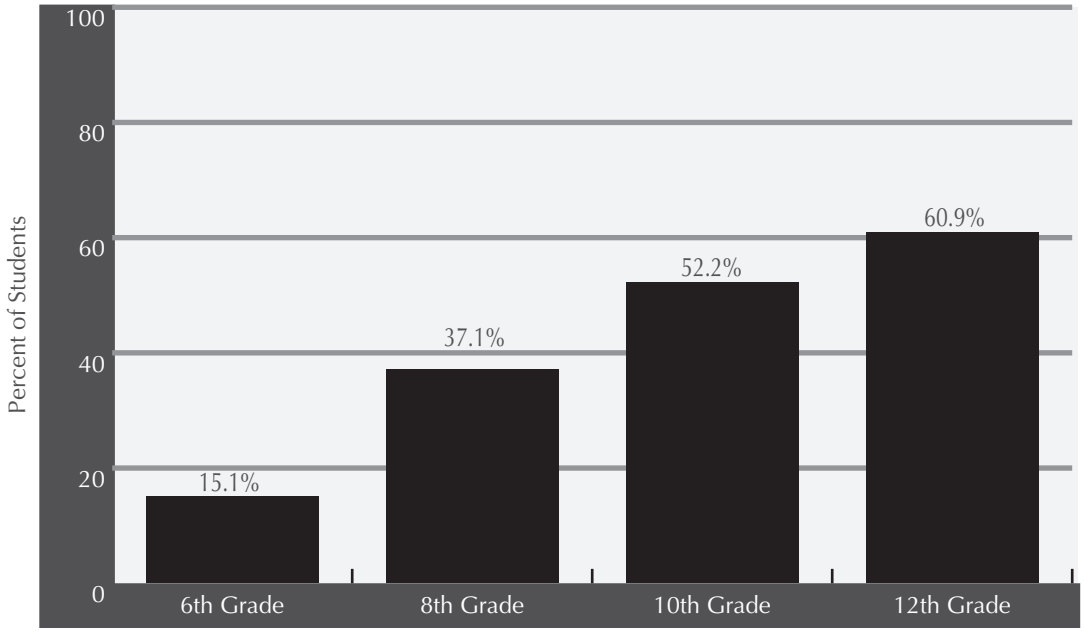
Tobacco use, particularly cigarette smoking, is the leading cause of preventable illness and death in the United States.[1] A 1996 federal Centers for Disease Control and Prevention study indicates that 33% of young smokers will eventually die as a result of tobacco use, if current use patterns continue.[2]

[1] Centers for Disease Control and Prevention (2000). Reducing tobacco use: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services.
[2] Centers for Disease Control and Prevention (1996). Projected smoking-related deaths among youth – United States. Morbidity and Mortality Weekly Report 45: 971-974.

* The Washington State Survey of Adolescent Health Behaviors (WSSAHB) 2000 was administered significantly earlier during the school year than in previous WSSAHBs. The result is that students were younger, with correspondingly less time in school. In addition, seasonal factors may have affected the results. Some of the questions were also changed. As Washington 2000 data may not be comparable to previous surveys or results from the national Monitoring the Future survey, it is not displayed here.

Source: National data from the National Institute on Drug Abuse, Monitoring the Future.
State data from the Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

By 12th Grade, More than 60% of Washington Adolescents Have Tried Smoking.



Source: Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

While the percentage of students who have tried smoking has remained relatively stable over the past decade, there are clear indications that in Washington State, experimentation and use of smokeless tobacco among students is on the decline.[1]

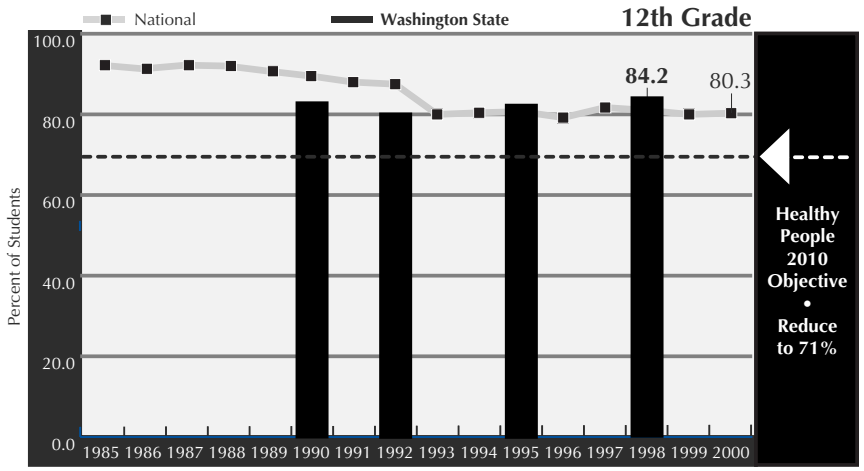
Healthy People 2010 notes that data from community research studies and other evidence indicates that increasing excise taxes on cigarettes, when combined with smoking campaigns, is one of the most cost-effective short-term strategies to prevent tobacco initiation among youth.[2]

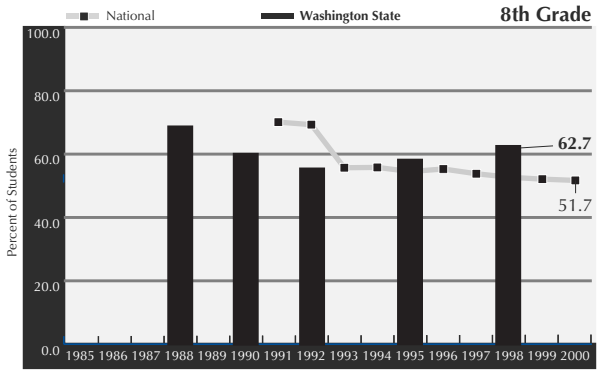
[1] Office of the Superintendent of Public Instruction, Washington state survey of adolescent health behaviors 2000, 33-34.
[2] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference edition), 27-6. Washington, DC .

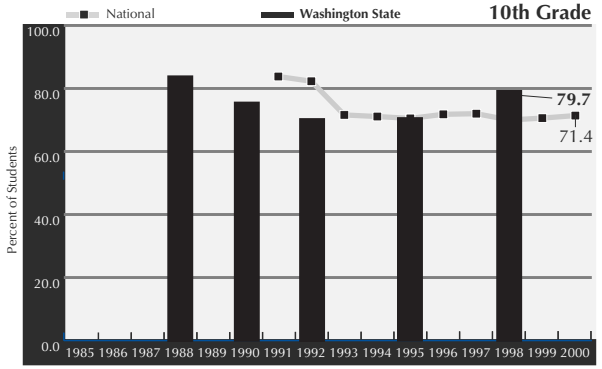
In 1998, a Higher Percentage of Washington State Students in Grades 8, 10, and 12 Had Tried Alcohol than Their Peers Nationally.*

These graphs indicate that in 1998, Washington State students in grades 8, 10, and 12 were more likely to have tried alcohol than students in these grades nationally.

Healthy People 2010 sets a target objective of increasing the percentage of high school seniors who have never tried alcohol to 29%.



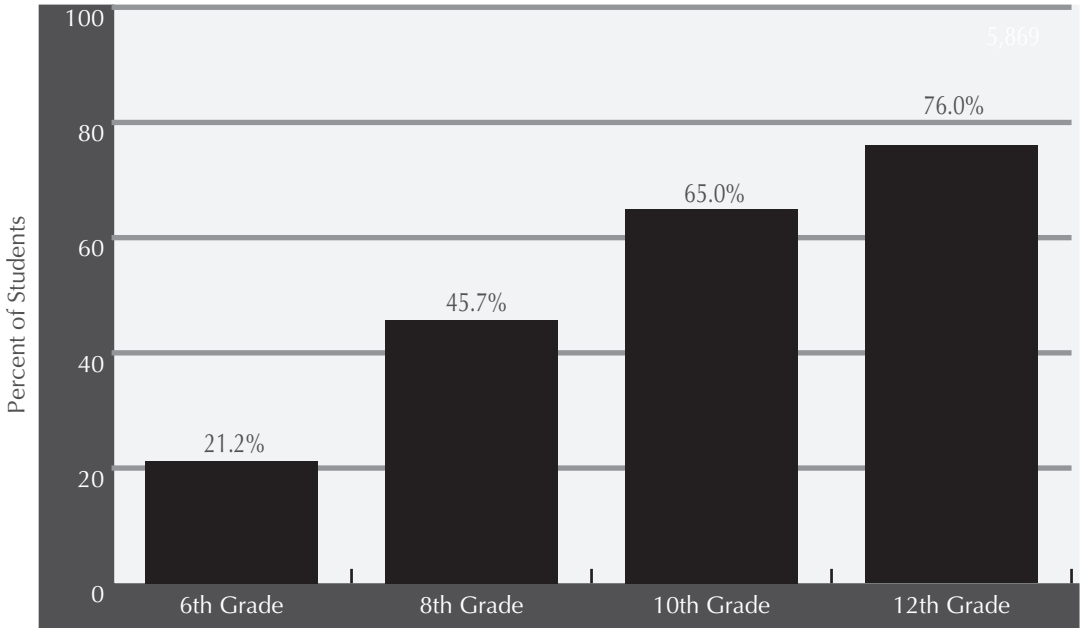




Source: National data from the National Institute on Drug Abuse, Monitoring the Future. State data from the Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

* The Washington State Survey of Adolescent Health Behaviors (WSSAHB) 2000 was administered significantly earlier during the school year than in previous WSSAHBs. The result is that students were younger, with correspondingly less time in school. In addition, seasonal factors may have affected the results. Some of the questions were also changed. As Washington 2000 data may not be comparable to previous surveys or results from the national Monitoring the Future survey, it is not displayed here.

By 12th Grade, More than Three Quarters of Washington Students Have Tried Alcohol.



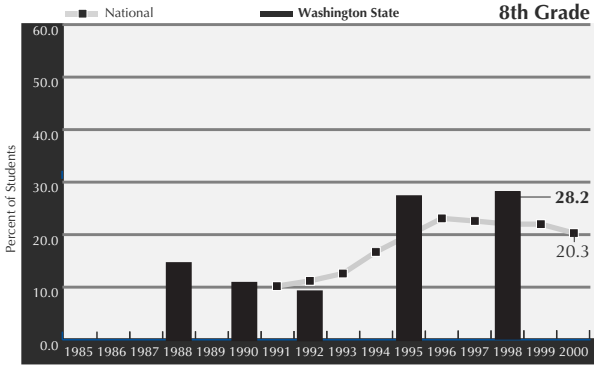
Source: Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

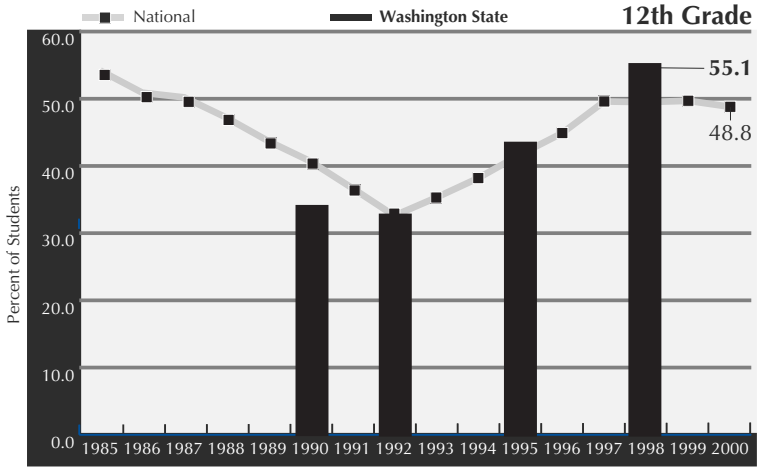
Almost half of Washington students have tried alcohol before they reach high school. ***Healthy People 2010*** sets a target objective of increasing the percentage of high school seniors who have never used alcohol to 29%

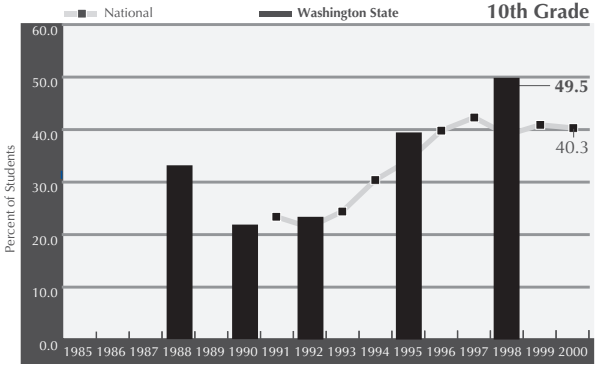
In 1998, a Higher Percentage of Washington State Students in Grades 8, 10, and 12 Had Tried Marijuana than Their Peers Nationally.*

These graphs indicate that in 1998, Washington State students in grades 8, 10, and 12 were more likely to have tried marijuana than students in these grades nationally. Besides being associated with a variety of health risks, marijuana can contribute to risky behaviors and adverse physical and social consequences.

Healthy People 2010 sets a target objective of increasing the percentage of high school seniors who have never used illicit drugs to 56%.



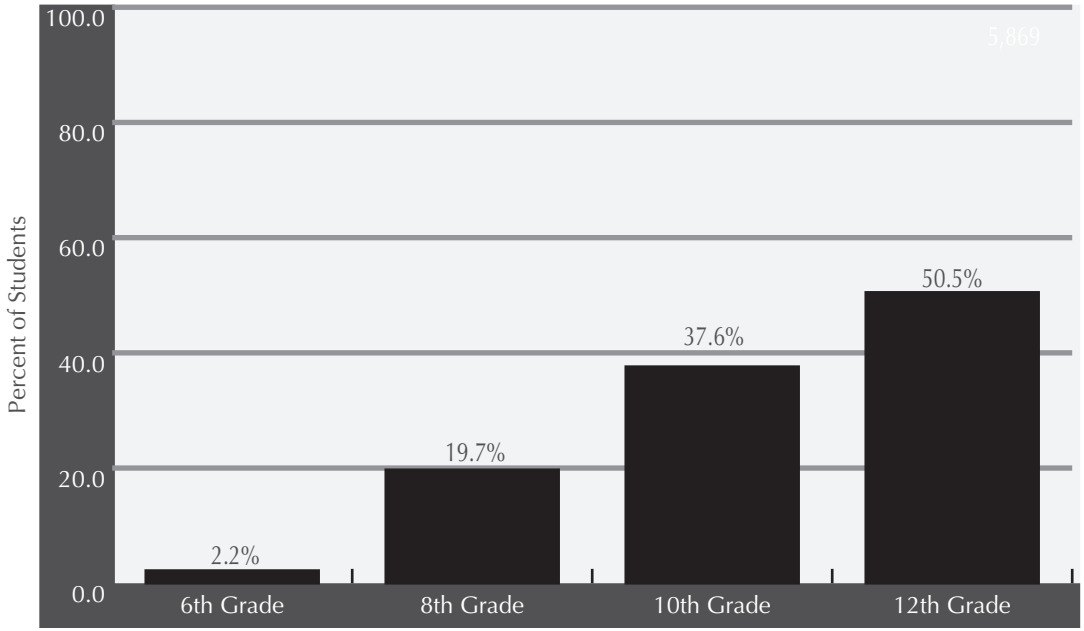




Source: National data from the National Institute on Drug Abuse, Monitoring the Future. State data from the Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

* The Washington State Survey of Adolescent Health Behaviors (WSSAHB) 2000 was administered significantly earlier during the school year than in previous WSSAHBs. The result is that students were younger, with correspondingly less time in school. In addition, seasonal factors may have affected the results. Some of the questions were also changed. As Washington 2000 data may not be comparable to previous surveys or results from the national Monitoring the Future survey, it is not displayed here.

By 12th Grade, More than Half of Washington Students Have Tried Marijuana.



Source: Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

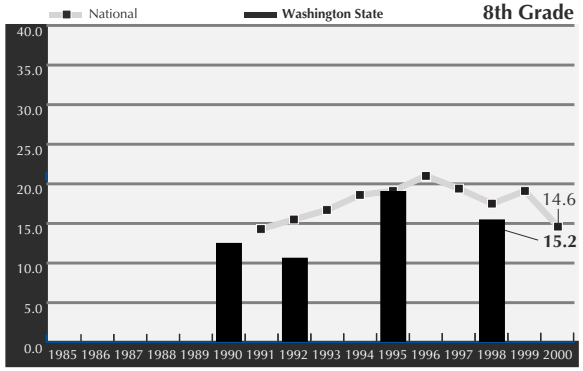
About one-fifth of Washington students begin use of marijuana while they are in middle school. A study by the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that substance abuse and addiction nationally added $41 billion, or 10%, to the cost of elementary and secondary education in 2001 due to class disruption and violence, special education and tutoring, teacher turnover, truancy, children being left behind, student assistance programs, property damage, injury, and counseling.

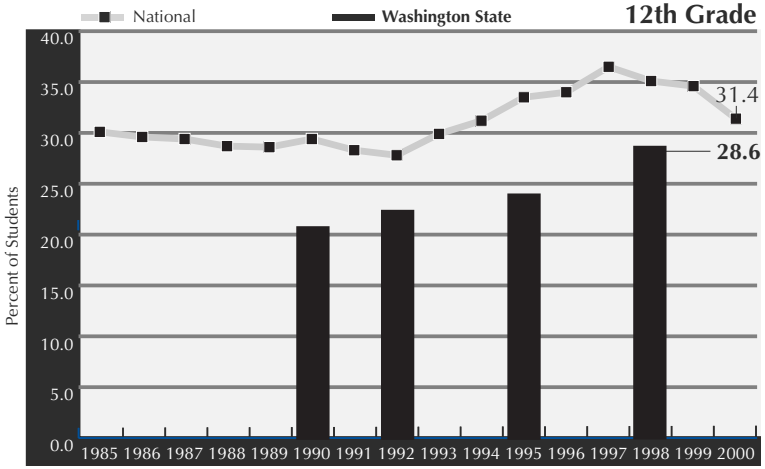
CASA also estimates that 60% of high school students and 30% of middle school students attend schools where illegal drugs are kept, sold, and used. Among 10th graders surveyed, 87% said it was easy to get tobacco, 88% to obtain alcohol, and 78% to get marijuana. [1]

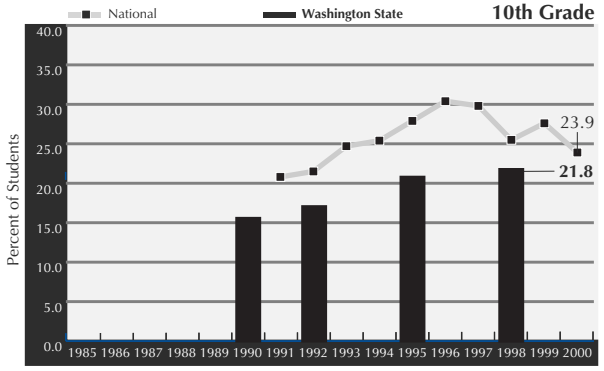
[1] National Center on Addiction and Substance Abuse at Columbia University. (2001). Malignant neglect: Substance abuse and America's schools. New York, NY.

In 1998, Washington State 8th, 10th, and 12th Graders were Less Likely to Have Smoked a Cigarette in the Past 30 Days than Their National Counterparts.*

This graph indicates that in 1998, Washington State students were less likely to have recently smoked a cigarette than students in similar grades nationally. ***Healthy People 2010*** sets a target objective to reduce cigarette smoking by students in grades 9-12 to 16%.



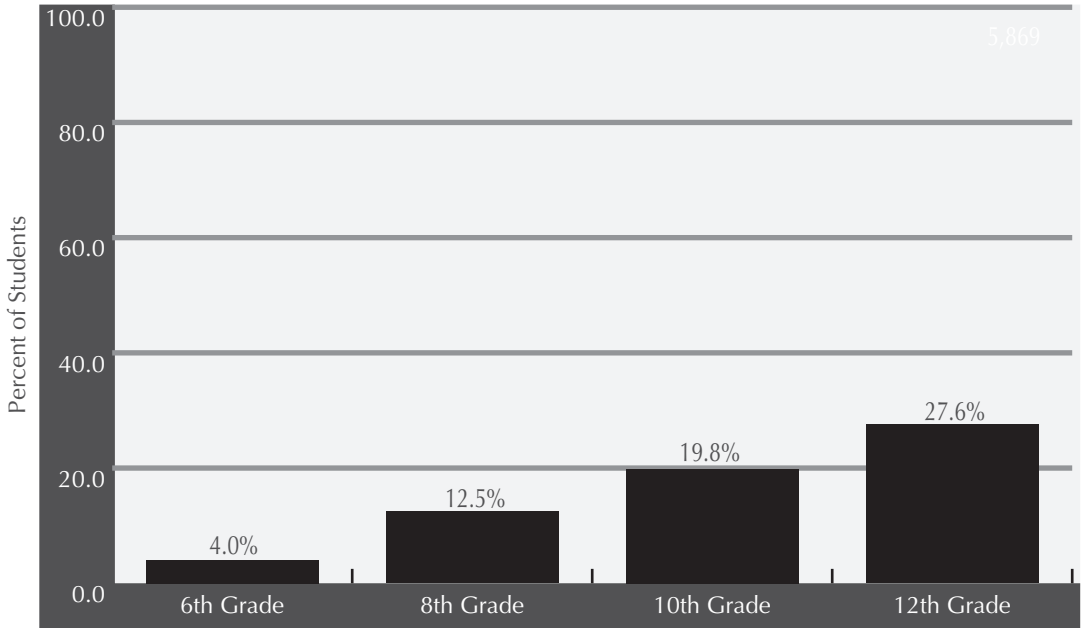




Source: National data from the National Institute on Drug Abuse, Monitoring the Future. State data from the Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

*The Washington State Survey of Adolescent Health Behaviors (WSSAHB) 2000 was administered significantly earlier during the school year than in previous WSSAHBs. The result is that students were younger, with correspondingly less time in school. In addition, seasonal factors may have affected the results. Some of the questions were also changed. As Washington 2000 data may not be comparable to previous surveys or results from the national Monitoring the Future survey, it is not displayed here.

By 12th Grade, More than a Quarter of Washington Students Report Having Smoked a Cigarette in the Past 30 Days.



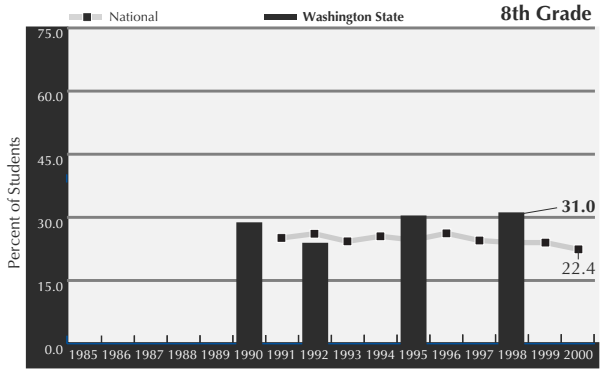
Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

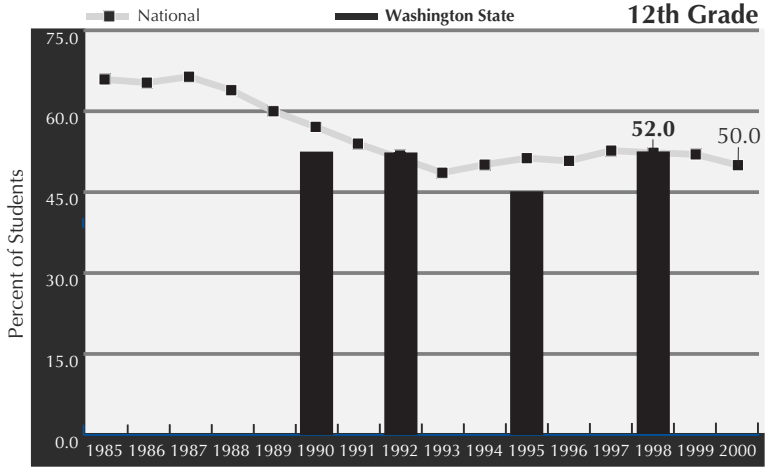
Among young people, short-term health consequences of smoking include respiratory and non-respiratory effects, nicotine addiction, and the associated risk of other drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who begin to smoke regularly in their youth continue to smoke as adults.[1] Nationally, almost 44% of high school seniors who smoke report that they would like to stop smoking. About 30% of high school seniors who smoke report that they have tried to quit but have failed to do so.[2]

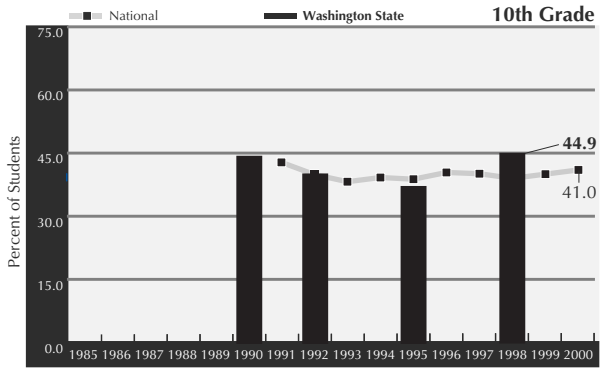
[1] Centers for Disease Control and Prevention. (1994). Tobacco use among young people – A report of the Surgeon General. Washington DC: U.S. Department of Social and Health Services.
[2] U.S. Department of Social and Health Services. (2000). Healthy people 2010 (Conference edition), 27-23.

In 1998, Washington 8th and 10th Graders were More Likely to Have Used Alcohol in the Past 30 Days than Their Counterparts Nationally.*

In 1998, Washington State high school seniors reported using alcohol in the past 30 days at the same rate as high school seniors nationally. A 2002 study found that teens drink one quarter of all alcohol consumed in the United States.[1]





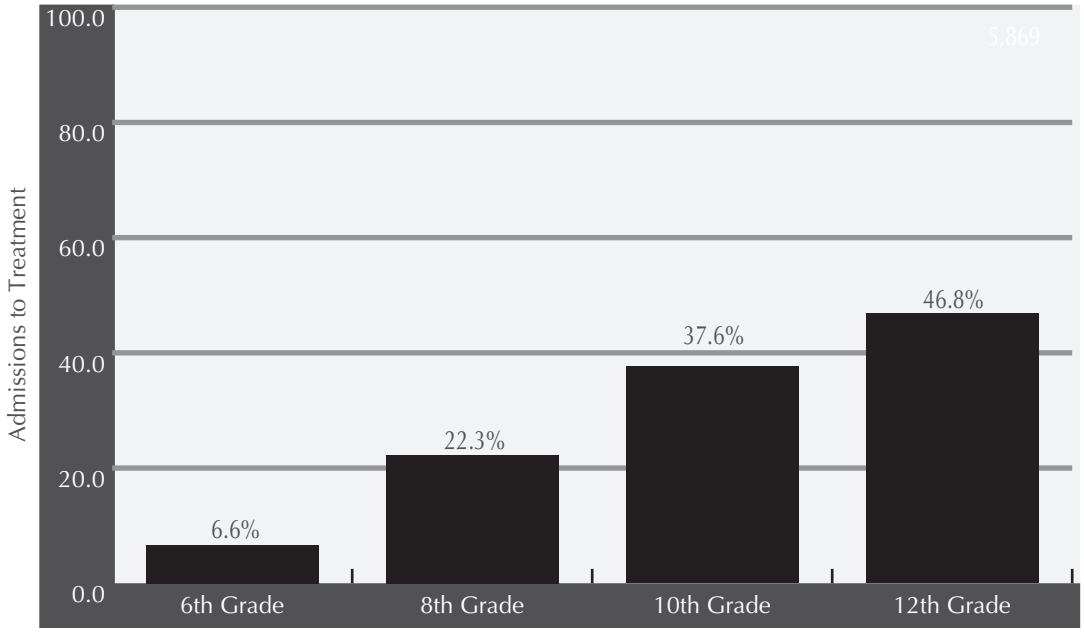


Source: National data from the National Institute on Drug Abuse, Monitoring the Future. State data from the Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

* The Washington State Survey of Adolescent Health Behaviors (WSSAHB) 2000 was administered significantly earlier during the school year than in previous WSSAHBs. The result is that students were younger, with correspondingly less time in school. In addition, seasonal factors may have affected the results. Some of the questions were also changed. As Washington 2000 data may not be comparable to previous surveys or results from the national Monitoring the Future survey, it is not displayed here.

[1] National Center on Addiction and Substance Abuse at Columbia University (2002). Teen Tipplers: America's Underage Drinking Epidemic. New York, NY.

Almost One Quarter of Washington State 8th Graders Report Having Used Alcohol in the Past 30 Days.

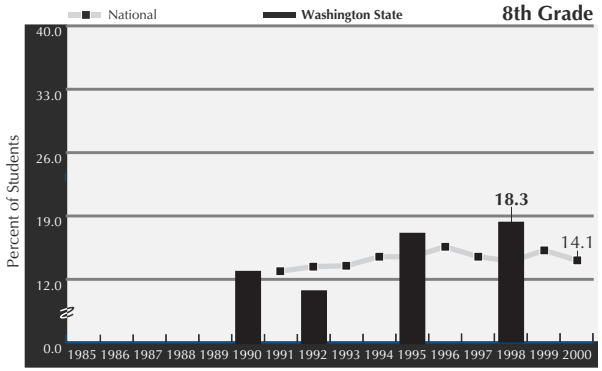


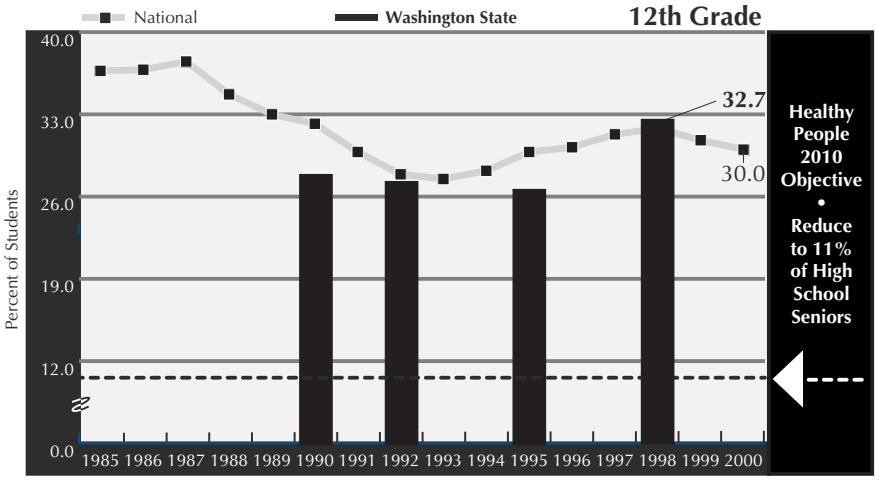
Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

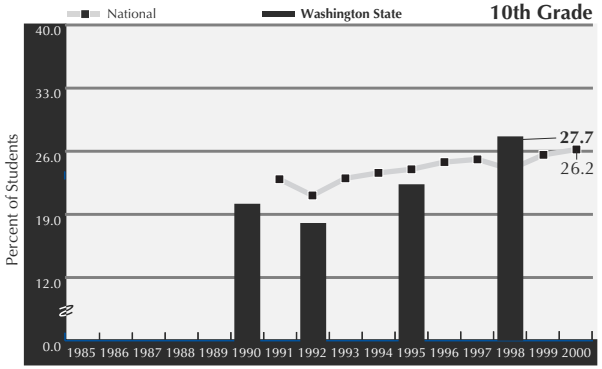
Regular use of alcohol among adolescents in Washington State appears to begin early. Almost a quarter of students in their last year of middle school report having used alcohol in the past 30 days. ***Healthy People 2010*** sets a target objective to increase the proportion of adolescents ages 12-17 not using alcohol or illicit drugs during the past 30 days to 89%.

In 1998, a Higher Percentage of Washington State 8th, 10th, and 12th Grade Students Engaged in Recent Binge Drinking than Their Counterparts Nationally.*

This graph indicates that in 1998 Washington State students were more likely to engage in recent binge drinking than students nationally. Recent binge drinking is defined as having five or more drinks in a row on at least one occasion in the past two weeks.



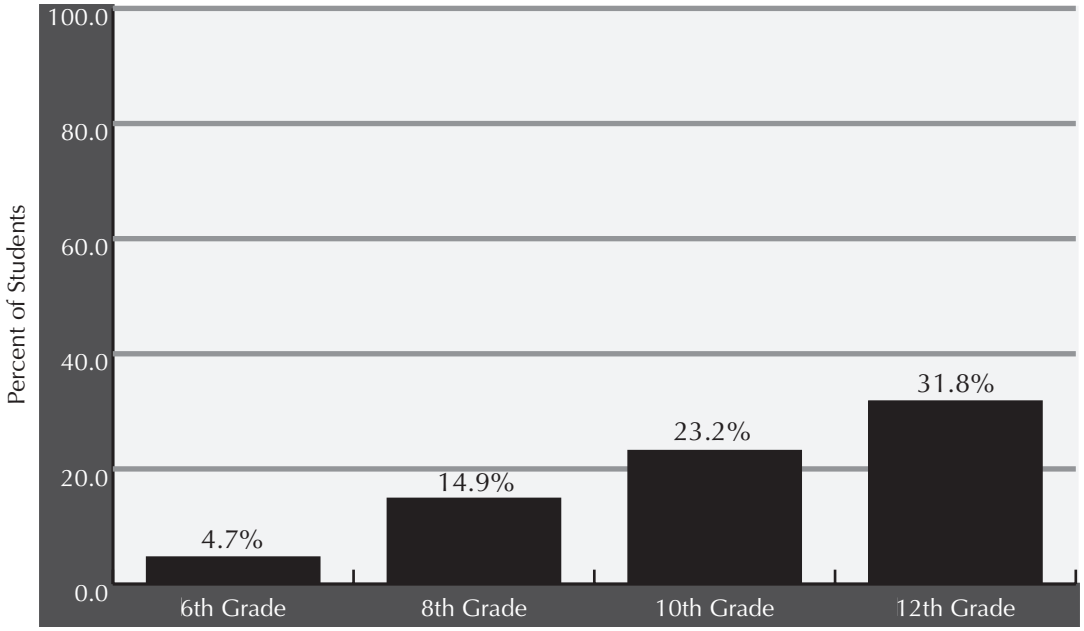




Source: National data from the National Institute on Drug Abuse, Monitoring the Future. State data from the Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

* The Washington State Survey of Adolescent Health Behaviors (WSSAHB) 2000 was administered significantly earlier during the school year than in previous WSSAHBs. The result is that students were younger, with correspondingly less time in school. In addition, seasonal factors may have affected the results. Some of the questions were also changed. As Washington 2000 data may not be comparable to previous surveys or results from the national Monitoring the Future survey, it is not displayed here.

In 2000, Almost 5% of Washington State 6th Graders Had Engaged in Recent Binge Drinking.

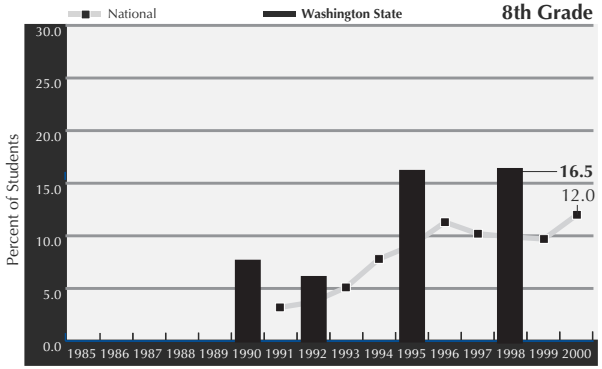


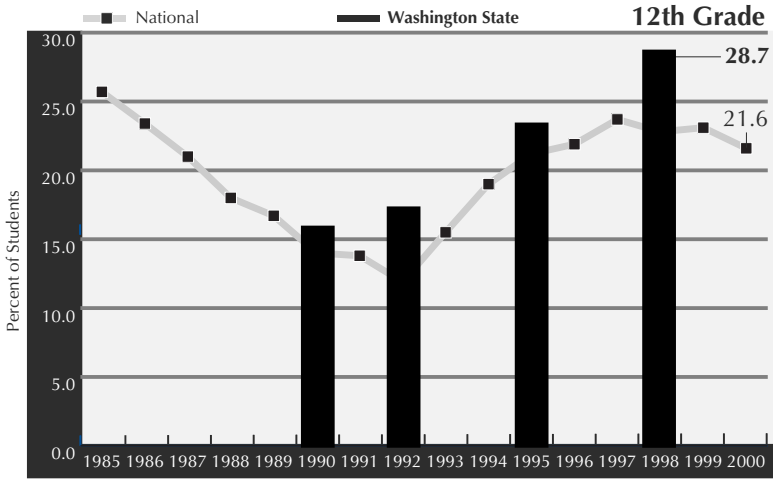
Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

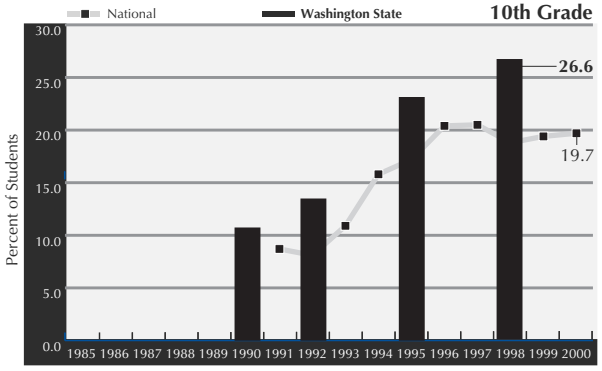
In 2000, almost one third of Washington State high school seniors had engaged in recent binge drinking. Heavy drinking among youth has been linked to motor vehicle crashes and deaths, physical fights, property destruction, poor school and employment performance, and involvement with law enforcement and the legal system. ***Healthy People 2010*** sets a target objective to reduce binge drinking among adolescents ages 12 to 17 in the past month to 3%.

In 1998, Washington Students in Grades 8, 10, and 12 were Much More Likely to Have Used Marijuana in the Past 30 Days than Their Counterparts Nationally.*

This graph indicates that in 1998 a higher percentage of Washington State students smoked marijuana in the past 30 days than students nationally. After significant increases in the past decade, national data suggest that marijuana use among students may now be on the decline.



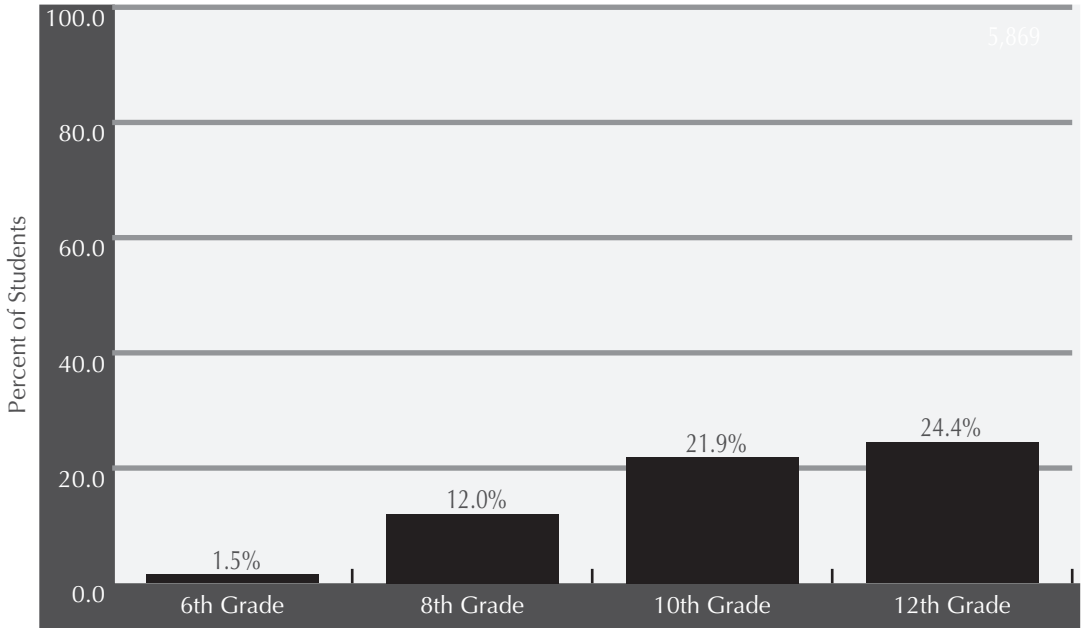




Source: National data from the National Institute on Drug Abuse, Monitoring the Future. State data from the Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

* The Washington State Survey of Adolescent Health Behaviors (WSSAHB) 2000 was administered significantly earlier during the school year than in previous WSSAHBs. The result is that students were younger, with correspondingly less time in school. In addition, seasonal factors may have affected the results. Some of the questions were also changed. As Washington 2000 data may not be comparable to previous surveys or results from the national Monitoring the Future survey, it is not displayed here.

About One Quarter of Washington State High School Seniors Report Having Used Marijuana in the Past 30 Days.

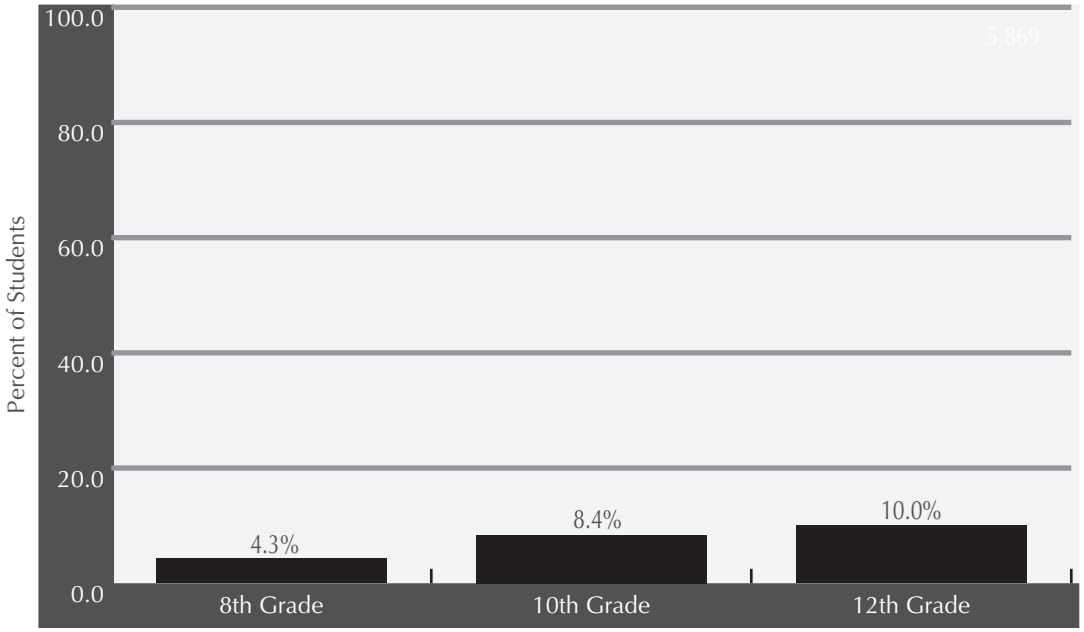


Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

Marijuana use among adolescents follows a predictable pattern, with the highest incidence of use occurring among high school seniors. ***Healthy People 2010*** recommends a multicomponent approach to youth substance abuse prevention to increase the effectiveness of efforts. Such an approach would include focusing on mobilizing and leveraging resources, raising public awareness, and countering pro-use messages.

[1]U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 26-28. Washington, DC.

In 2000, One Out of Ten Washington State High School Seniors Reported Having Used Amphetamines, Including Methamphetamine.

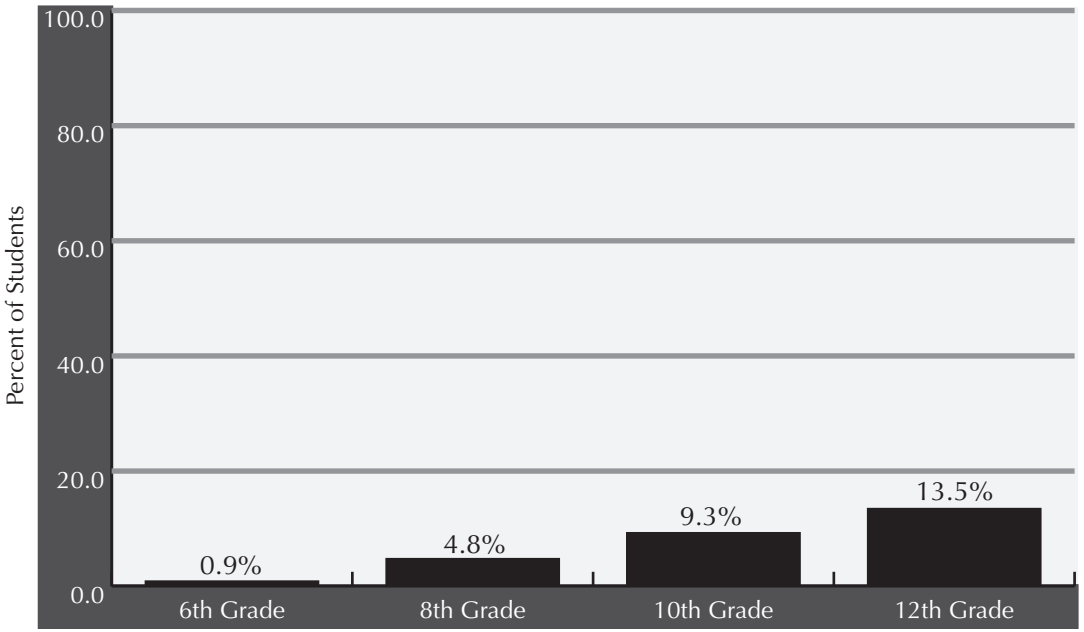


Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

Data from the Washington State Survey of Adolescent Health Behaviors 2000 suggest that there have been substantial increases in methamphetamine use in Washington State among youth. Researchers funded by the National Institute on Drug Abuse have found a range of negative cognitive effects from use of methamphetamine, often associated with brain cell damage.[1]

[1]National Institute on Drug Abuse. (2000). NIDA notes – Research findings. 15:4

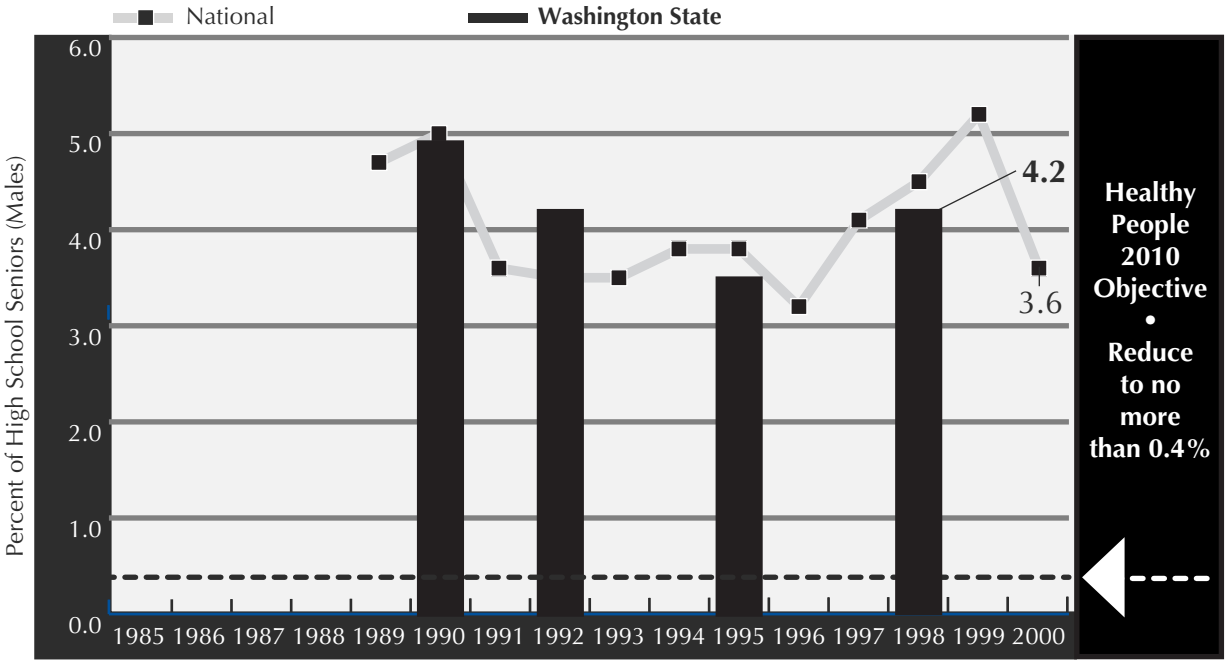
In 2000, More than 13% of Washington State High School Seniors Reported Having Used Party/Club Drugs.



Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

In 2000, about one out of seven high school seniors reported having used party drugs (also known as "club drugs", and including Ecstasy and MDMA) in their lifetime; 6.8% report having used these drugs in the past 30 days; 3% reported using them three times or more.

In 1998, More than 4% of Washington State Male High School Seniors Reported Having Used Steroids at Least Once.*



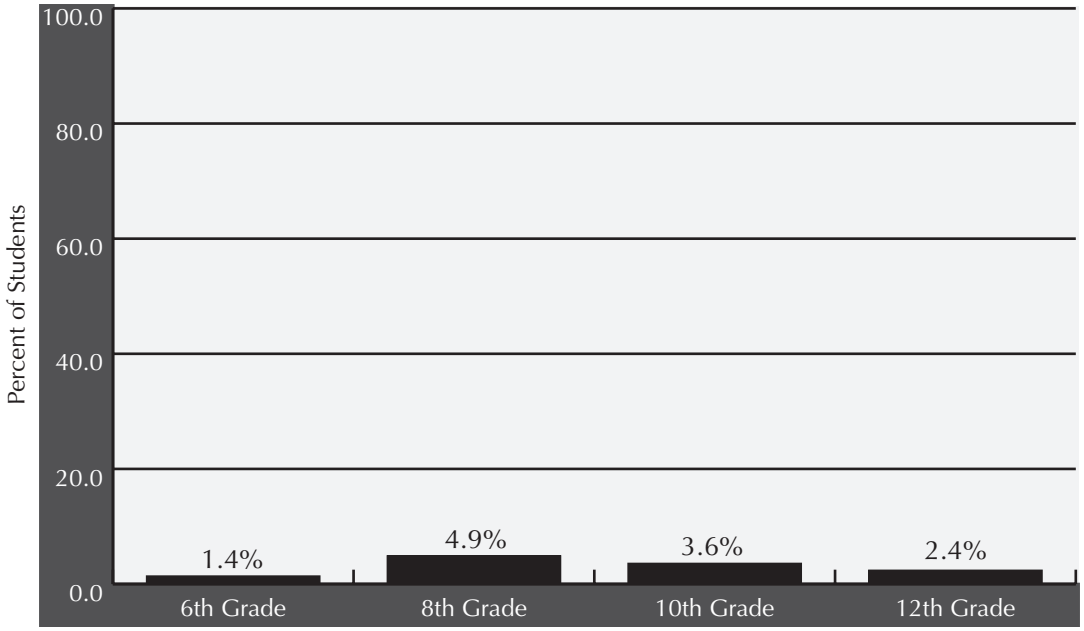
Source: National data from the National Institute on Drug Abuse, Monitoring the Future. State data from the Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

* The Washington State Survey of Adolescent Health Behaviors (WSSAHB) 2000 was administered significantly earlier during the school year than in previous WSSAHBs. The result is that students were younger, with correspondingly less time in school. In addition, seasonal factors may have affected the results. Some of the questions were also changed. As Washington 2000 data may not be comparable to previous surveys or results from the national Monitoring the Future survey, it is not displayed here.

Behavioral and health problems associated with steroid use include suicides, homicides, liver damage, and heart attacks.[1] It should be noted that in 2000, 1.2% of Washington State female high school seniors report having used steroids as well.

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 26-36. Washington DC

Use of Inhalants in the Past 30 Days Among Washington State Students Peaks in the 8th Grade.

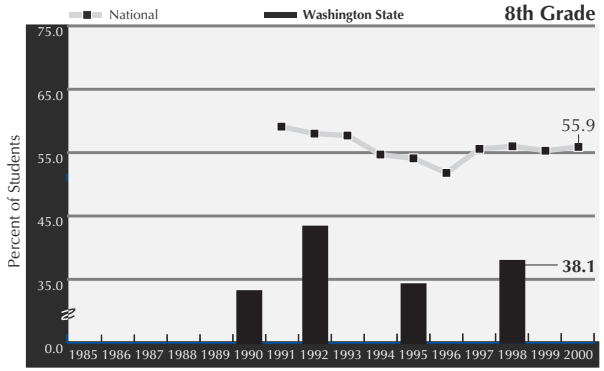


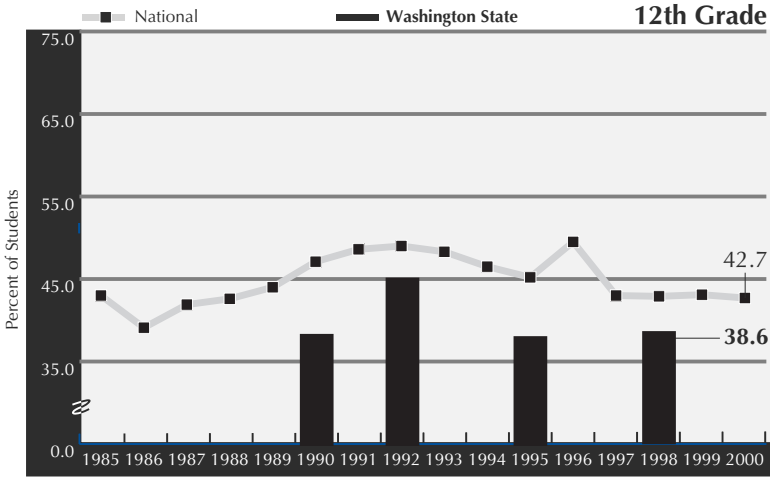
Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

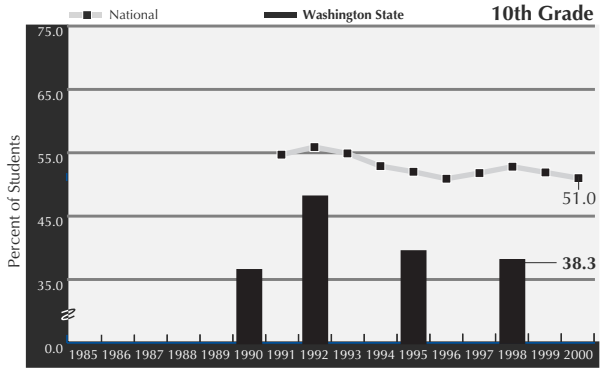
In 2000, Washington State 8th graders reported the highest use of inhalants among students in the previous 30 days. Thereafter, unlike the pattern for other drug and alcohol use, inhalant use seems to decline. Some 13.1% of Washington State high school seniors report having used inhalants at least once in their lives.

In 1998, a Lower Percentage of Washington State 8th, 10th, and 12th Graders Perceived Great Risk from Heavy Alcohol Use than Their Counterparts Nationally.*

This graph indicates that in 1998 the percentage of Washington State students who perceive great risk from heavy alcohol use (consuming five or more drinks once or twice a week) is lower than that of students nationally. ***Healthy People 2010*** sets a target objective to increase the percentage of adolescents ages 12 to 17 who perceive great risk associated with heavy alcohol use to 80%.



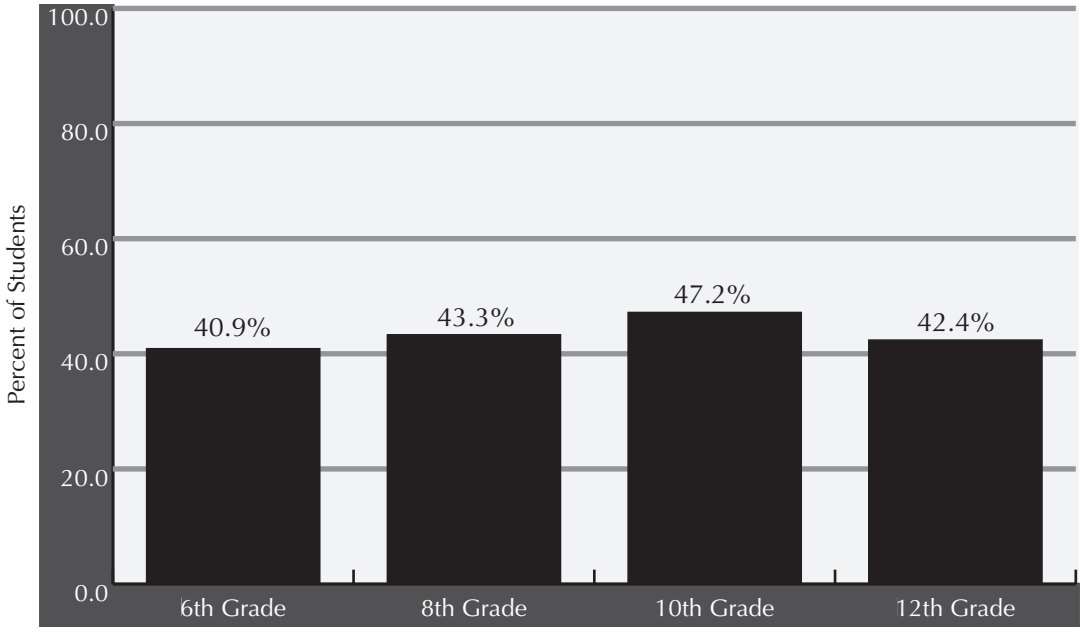




Source: National data from the National Institute on Drug Abuse, Monitoring the Future. State data from the Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

* The Washington State Survey of Adolescent Health Behaviors (WSSAHB) 2000 was administered significantly earlier during the school year than in previous WSSAHBs. The result is that students were younger, with correspondingly less time in school. In addition, seasonal factors may have affected the results. Some of the questions were also changed. As Washington 2000 data may not be comparable to previous surveys or results from the national Monitoring the Future survey, it is not displayed here.

In 2000, Fewer than Half of Washington State Students in Grades 6, 8, 10, and 12 Perceived Great Risk from Heavy Alcohol Use.



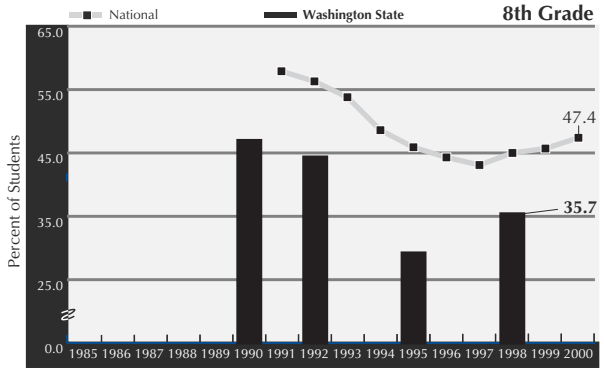
Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Risk Behaviors 2000.

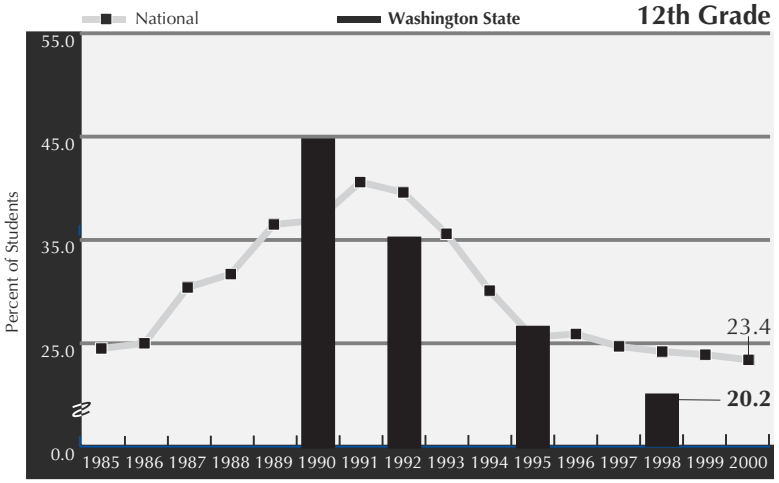
Research indicates that attitudes about specific drugs and alcohol are among the most important determinants of actual use.[1] Among Washington State students, there is no clear pattern of increased perception of risk from heavy alcohol use (defined as consuming five or more drinks once or twice or week). This may be due to the fact that despite repeated prevention messages delivered in the school environment, students are barraged with advertising messages actively promoting alcohol use.

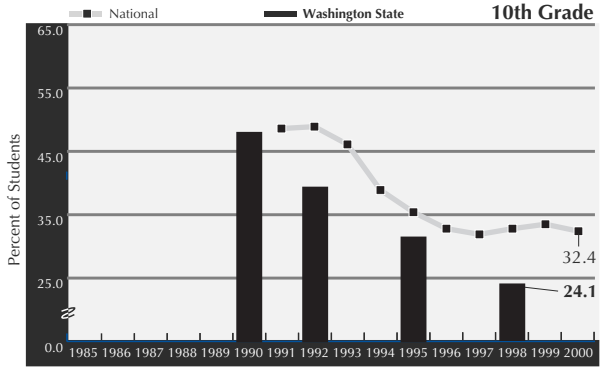
[1] Bachman, J., Johnston, L., and O'Malley, P. (1998). Explaining recent increase is students' marijuana use: Impacts of perceived risks and disapproval, 1976 through 1996. American Journal of Public Health 88(6), 887-892.

In 1998, Washington State 8th, 10th, and 12th Graders were Less Likely than Their Counterparts Nationally to Perceive Great Risk from Occasional Marijuana Use.*

There are indications that, after a decade of decline, the percentages of students both nationally and in Washington State who associate risk of harm with occasional use of marijuana may be on the increase.







Source: National data from the National Institute on Drug Abuse, Monitoring the Future. State data from the Office of Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors.

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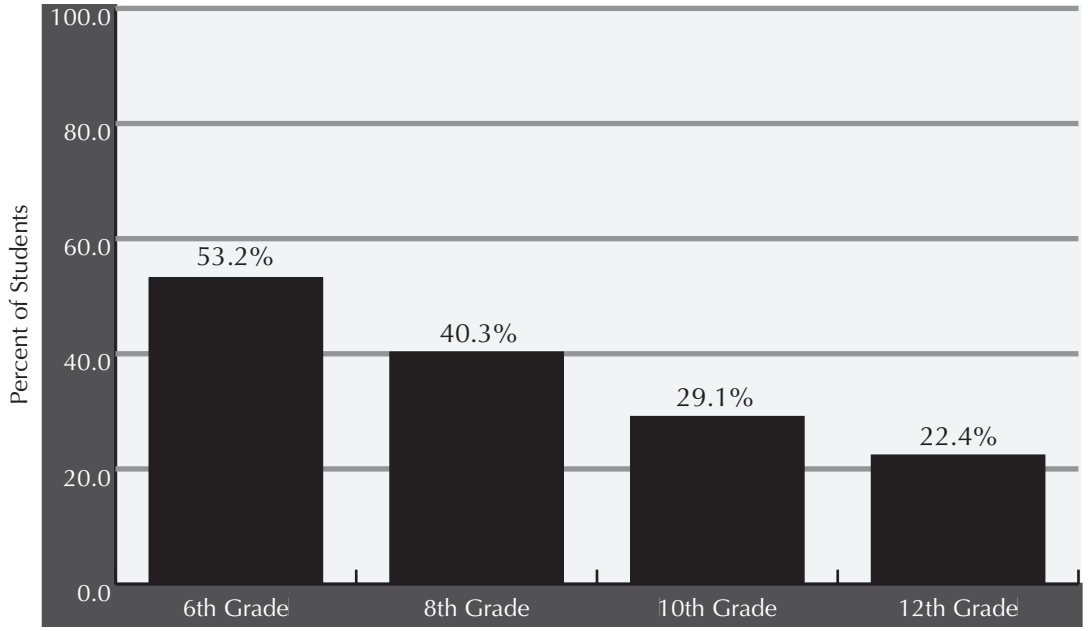
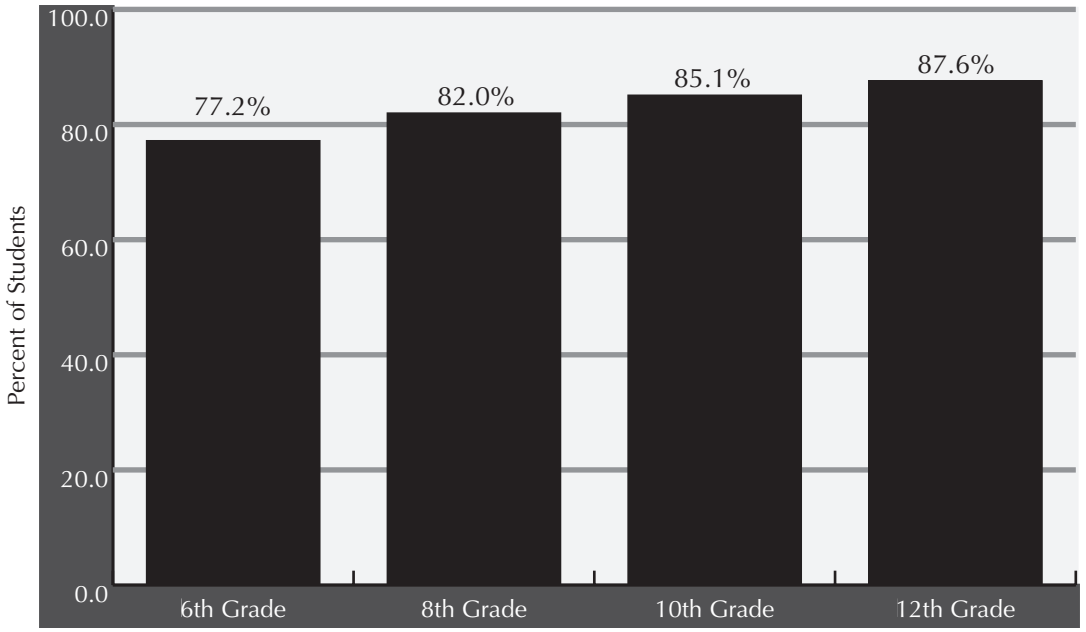
The Percentage of Washington State Students Who Perceive Great Risk from Occasional Marijuana Use Declines Substantially as They Get Older.



Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

In 2000, the percentage of Washington State students who perceive great risk from occasional marijuana use declined from 53.2% among 6th graders to 22.4% among high school seniors. It should be noted, however, that the percentage of Washington State high school seniors who perceive great risk from smoking marijuana regularly rises to 58.9%. ***Healthy People 2010*** sets a target objective to increase the proportion of adolescents ages 12 to 17 who perceive great risk from marijuana use once per month.

Most Washington State Students Perceive Great Risk from Smoking One or More Packs of Cigarettes Per Day.



Source: Office of the Superintendent of Public Instruction, Washington State Survey of Adolescent Health Behaviors 2000.

The proportion of Washington State youth who perceive great risk from smoking one or more packs of cigarettes per day increases as they get older. This would suggest the success of prevention activities and media in effectively conveying the dangers of smoking. Only 1.5% of high school seniors thought there was a "very good chance" of their being "seen as cool" if they smoked cigarettes. However, the same 2000 survey found that only 27.5% of 12th graders thought it "very wrong" for a person their age to smoke.

Peer Substance Abuse Has Significant Negative Impacts on School Performance.

In a study undertaken by Washington Kids Count at the University of Washington's Human Services Policy Center, data from the results of the 1999 Washington Assessment on Student Learning tests were linked with the results of the 1998 Washington Survey of Adolescent Health Behaviors administered in Washington schools. Peer substance use was calculated as the average level of alcohol or drug use by students of the same age, gender, and race-ethnic group in the school.

Among middle schoolers:

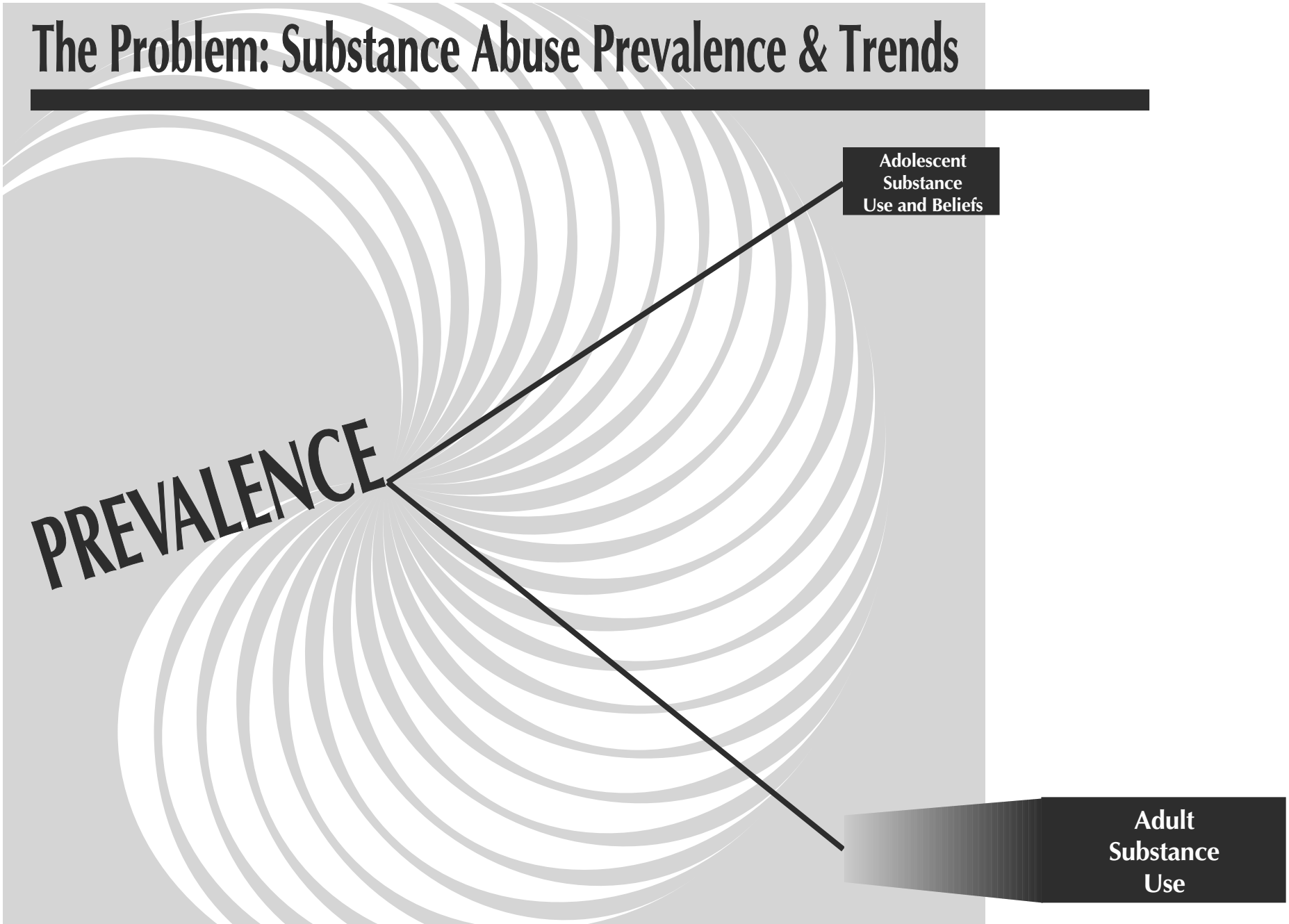
- *Students whose peers had little or no involvement with drinking and drugs scored substantially higher than students whose peers had a low level of drinking or drug use.*

- *The entire average difference in whether or not students met the state reading and math standards was accounted for by the degree to which their peers used alcohol or other drugs.*

- *The most important factors reliably indicating the level of substance abuse in a school are whether students start antisocial behavior at an early age, whether the prevailing attitudes of the students condone or condemn antisocial behavior, and whether students have opportunities for productive involvement in school and community acitivites.*[1]

[1] Brandon. N. (2001). Impact of peer substance use on middle school performance in Washington: summary. Seattle, WA: Washington Kids Count, Human Services Policy Center, University of Washington.

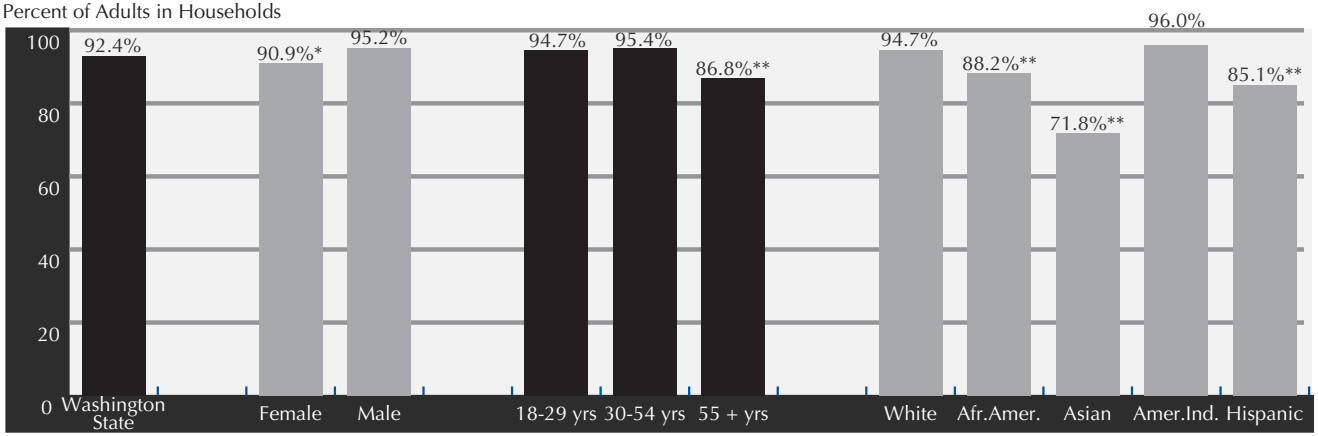
The Problem: Substance Abuse Prevalence & Trends



Being Age 55 or Older, Female, or of Minority Racial/Ethnic Status Are Associated with LOWER Lifetime and Past 30-Day Alcohol Use Rates.

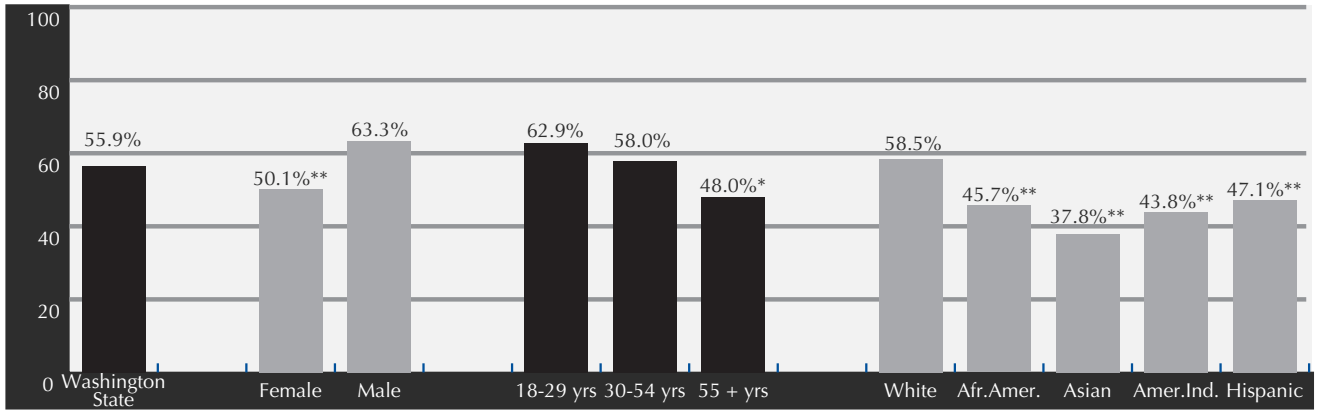
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30 Day Use of Alcohol

Percent of Adults in Households



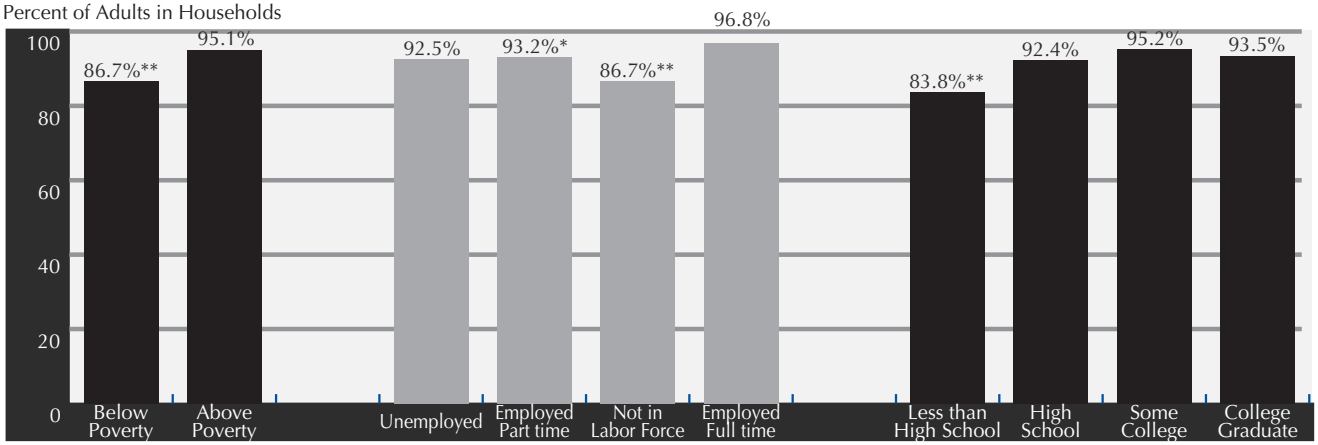
Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30 day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.
Note: Starred groups are "statistically" significantly different from their reference group. p<.10*, p<.05**.

Being Poor, Not in the Labor Force*, or Having No High School Diploma Are Associated with LOWER Lifetime and 30-Day Alcohol Use Rates.

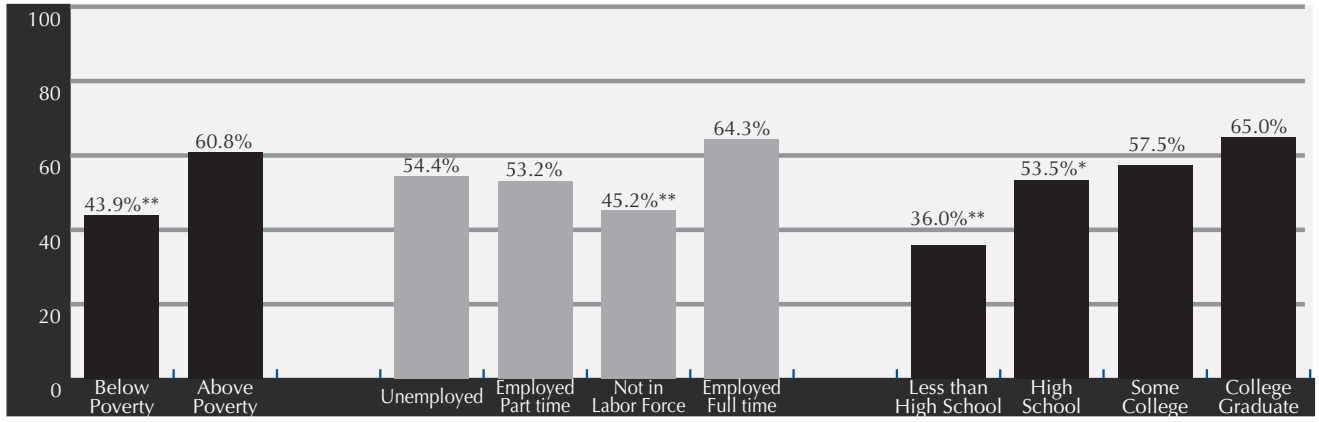
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30 Day Use of Alcohol

Percent of Adults in Households



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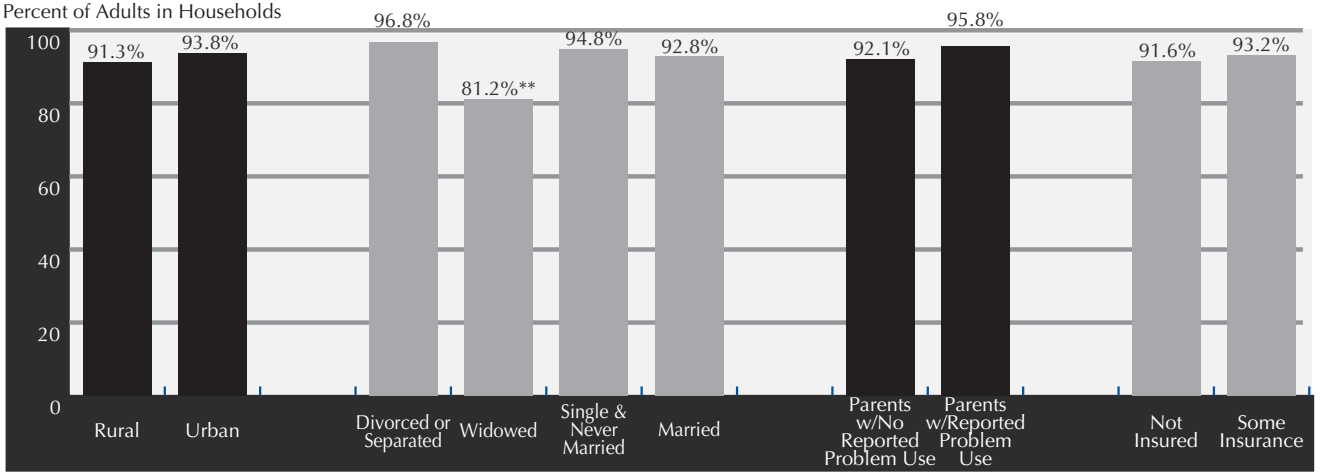
Note: Starred groups are "statistically" significantly different from their reference group. p<.10*, p<.05**.
*Not in Labor Force means Not Employed AND either Retired, OR a Full-Time Homemaker, OR a Full-Time Student.

Being Widowed is Associated with LOWER Lifetime and 30-Day Alcohol Use Rates.

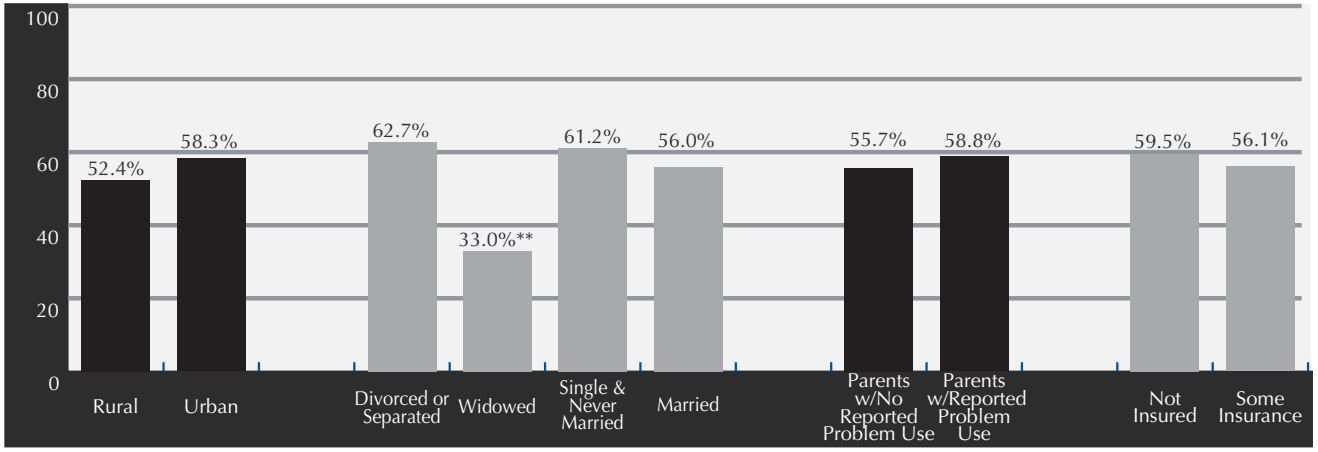
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30 Day Use of Alcohol

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

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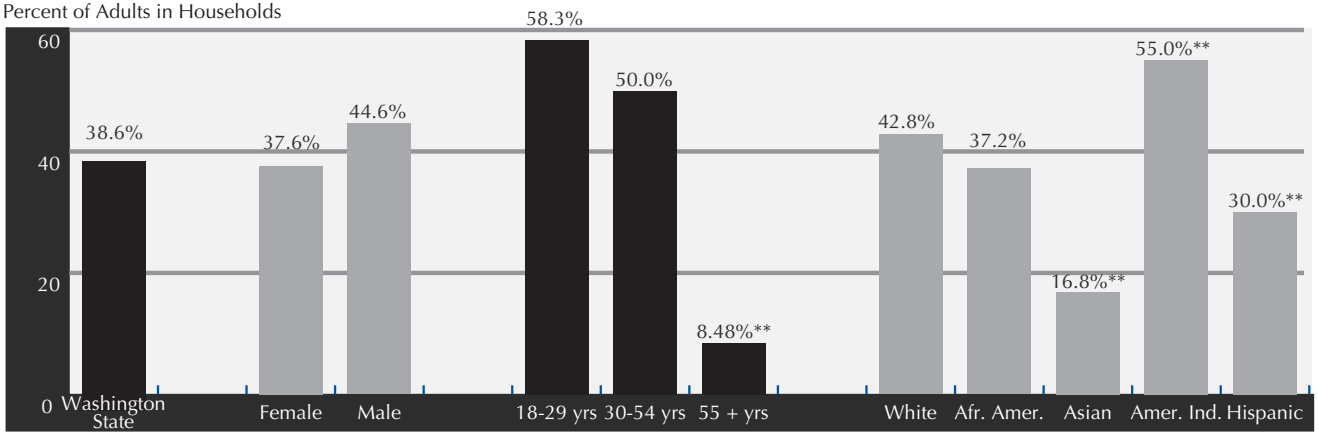
Note: Starred groups are “statistically” significantly different from their reference group. p<.10*, p<.05**.

Being Age 55 or Older, Asian, Hispanic or Female are Associated with LOWER Lifetime and Past 30-Day Marijuana Use Rates.

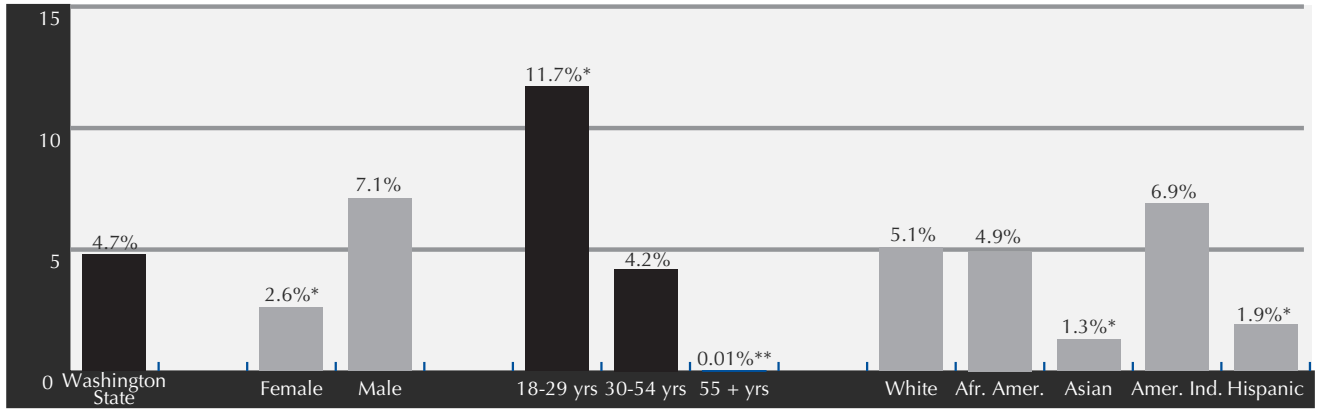
Lifetime Use of Marijuana

Percent of Adults in Households



Past 30 Day Use of Marijuana

Percent of Adults in Households



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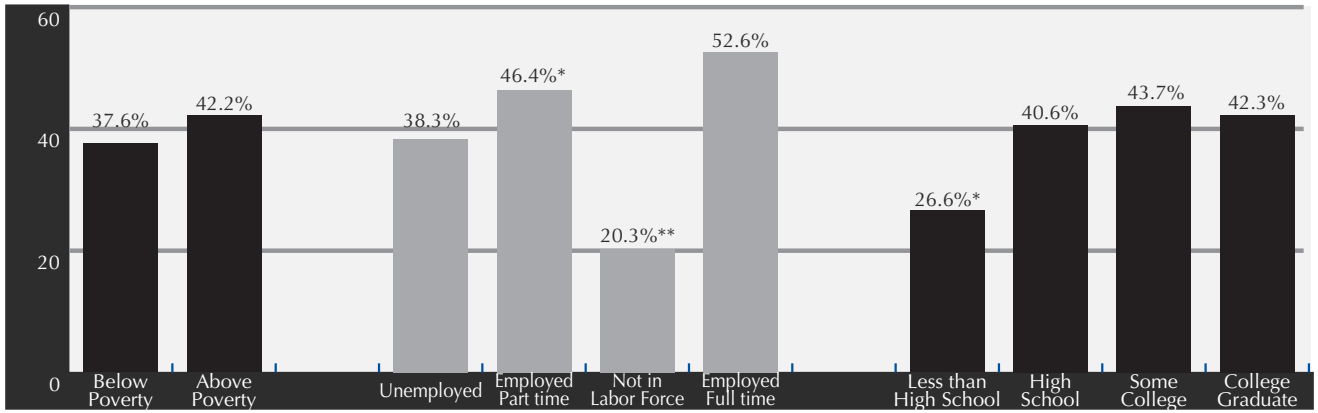
Note: Starred groups are “statistically” significantly different from their reference group. p<.10*, p<.05**.

Not Being in the Labor Force* is Associated with LOWER Lifetime and Past 30-Day Marijuana Use Rates.

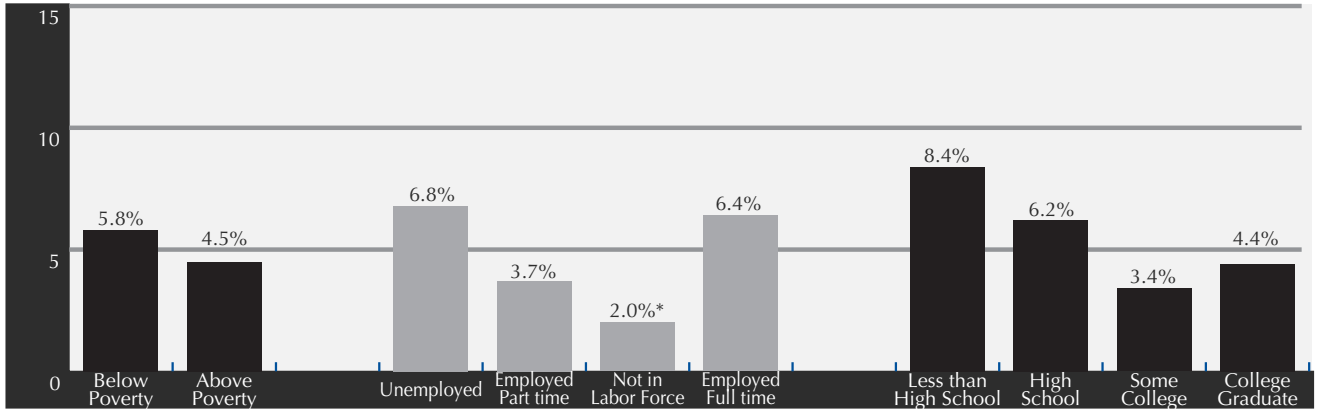
Lifetime Use of Marijuana

Percent of Adults in Households



Past 30 Day Use of Marijuana

Percent of Adults in Households



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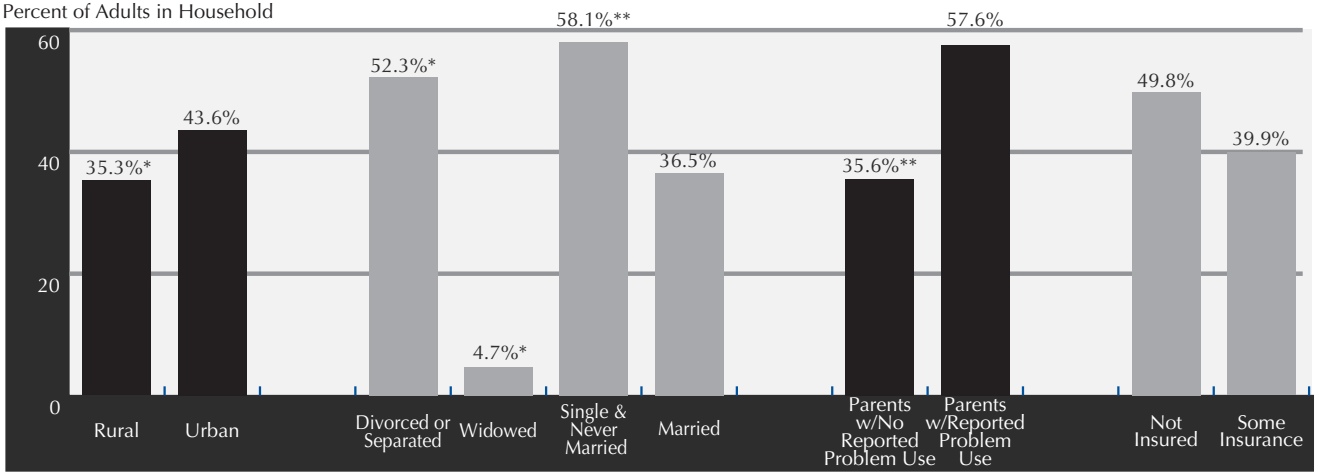
Note: Starred groups are "statistically" significantly different from their reference group. p<.10*, p<.05**.
*Not in Labor Force means Not Employed AND either Retired, OR a Full-Time Homemaker, OR a Full-Time Student.

Being Single and Never Married, Divorced or Separated, or Having Parents with Reported Drug or Alcohol Problems are Associated with HIGHER Lifetime and Past 30-Day Marijuana Use Rates.

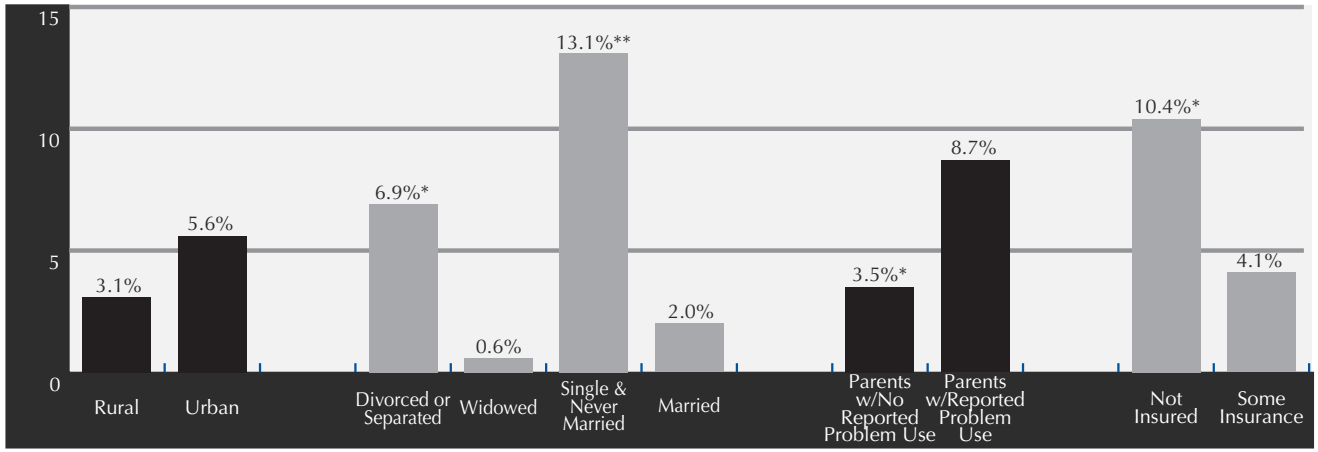
Lifetime Use of Marijuana

Percent of Adults in Household



Past 30 Day Use of Marijuana

Percent of Adults in Household



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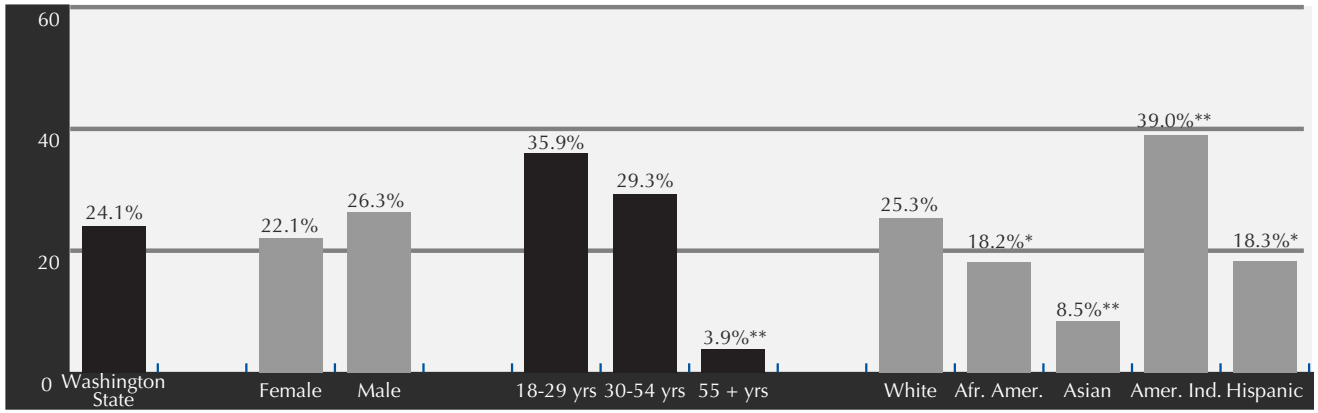
Note: Starred groups are "statistically" significantly different from their reference group. p<.10*, p<.05**.

Persons Who Were Age 55 or Older, or Asian Reported LOWER Rates of Both Lifetime and Past Year Hard Drug Use. HIGHER Lifetime Hard Drug Use was Reported by American Indians. HIGHER Past Year Hard Drug Use was Reported by Young Adults Under 30.

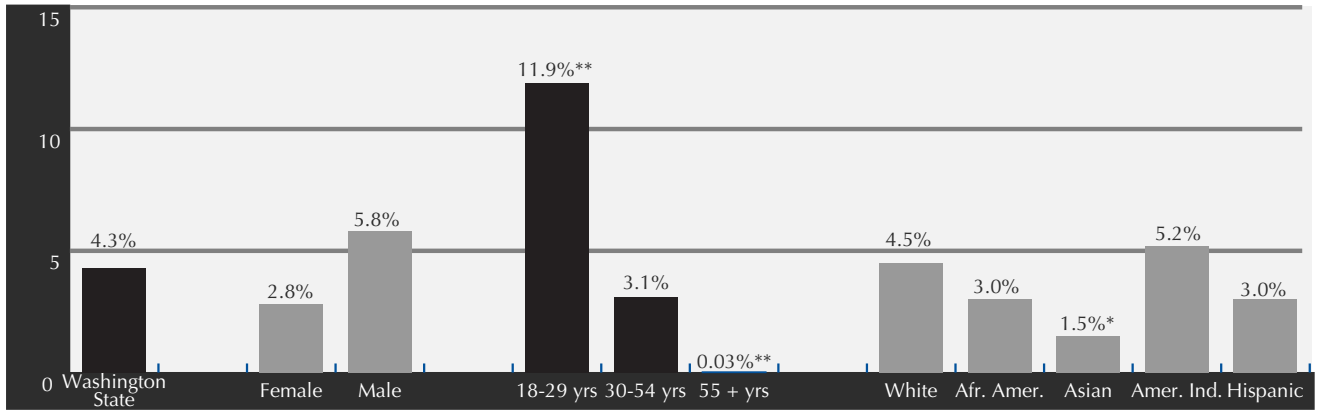
Lifetime Use of Hard Drugs

Percent of Adults in Households



Past 12 Month Use of Hard Drugs

Percent of Adults in Households



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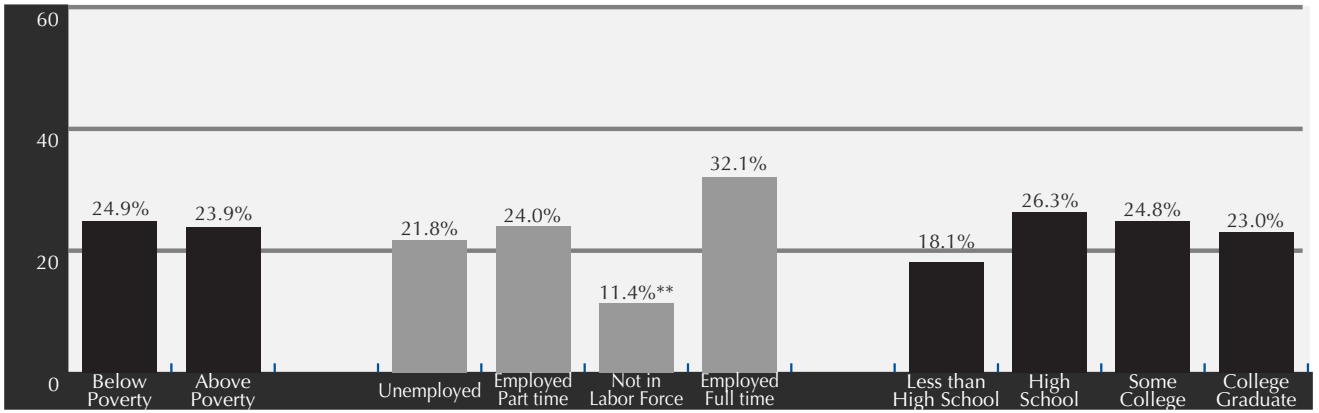
Note: Past 30 day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.
Note: Starred groups are "statistically" significantly different from their reference group. p<.10*, p<.05**.
*Not in Labor Force means Not Employed AND either Retired, OR a Full-Time Homemaker, OR a Full-Time Student.

People Who Were Not in the Labor Force* Reported Lower Rates of Lifetime and Past Year Use of Hard Drugs.

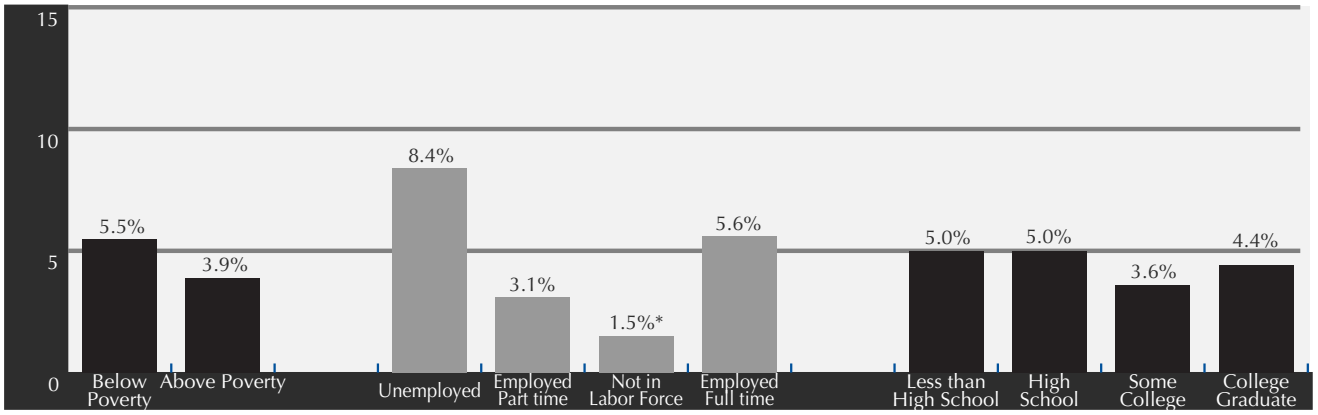
Lifetime Use of Hard Drugs

Percent of Adults in Households



Past 12 Month Use of Hard Drugs

Percent of Adults in Households



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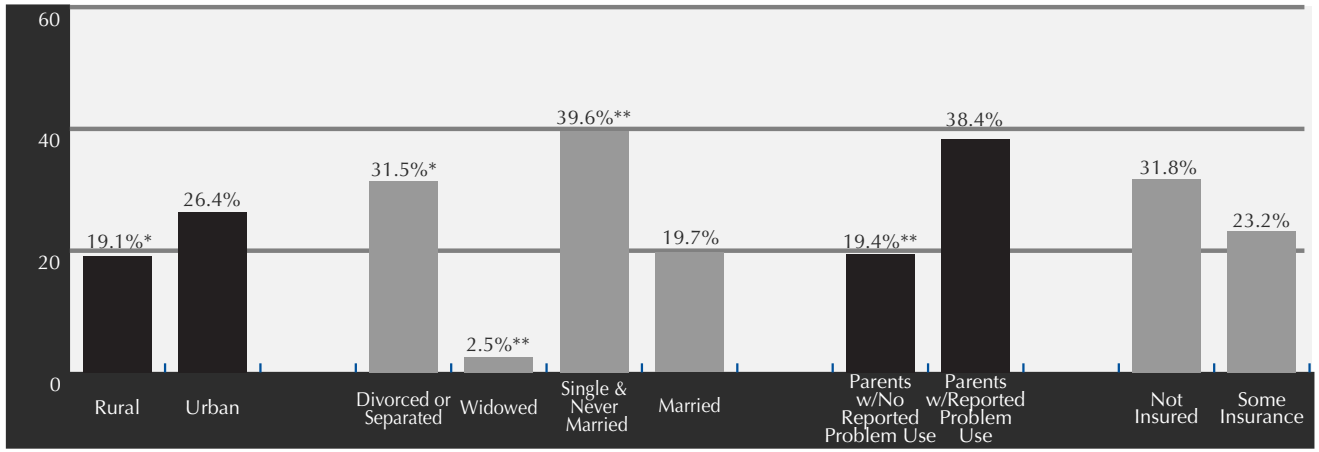
Note: Starred groups are "statistically" significantly different from their reference group. p<.10*, p<.05**.
*Not in Labor Force means Not Employed AND either Retired, OR a Full-Time Homemaker, OR a Fulltime Student.
**"Hard drugs" are any of the following substances used for non-medical purposes: sedatives, heroin, stimulants, hallucinogens, and other opiates.

People Who Were Divorced or Separated, Single and Never Married, Lived in Urban Counties, or Had Parents with Problem Drug or Alcohol Use Reported HIGHER Lifetime Use of Hard Drugs. All but the Last Condition were Also associated with HIGHER Past Year Hard Drug Use Rates.

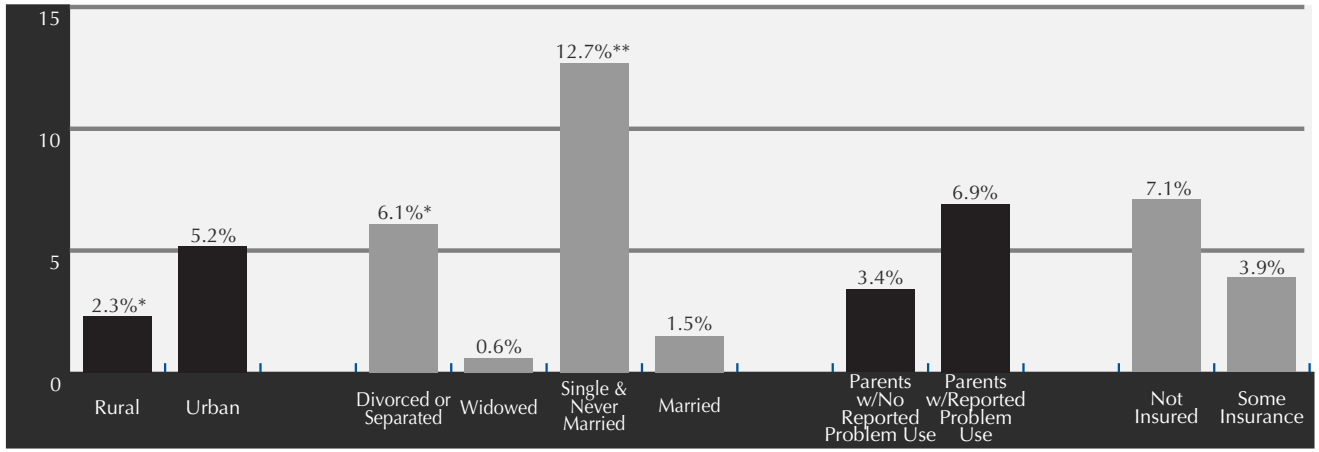
Lifetime Use of Hard Drugs

Percent of Adults in Household



Past 12 Month Use of Hard Drugs

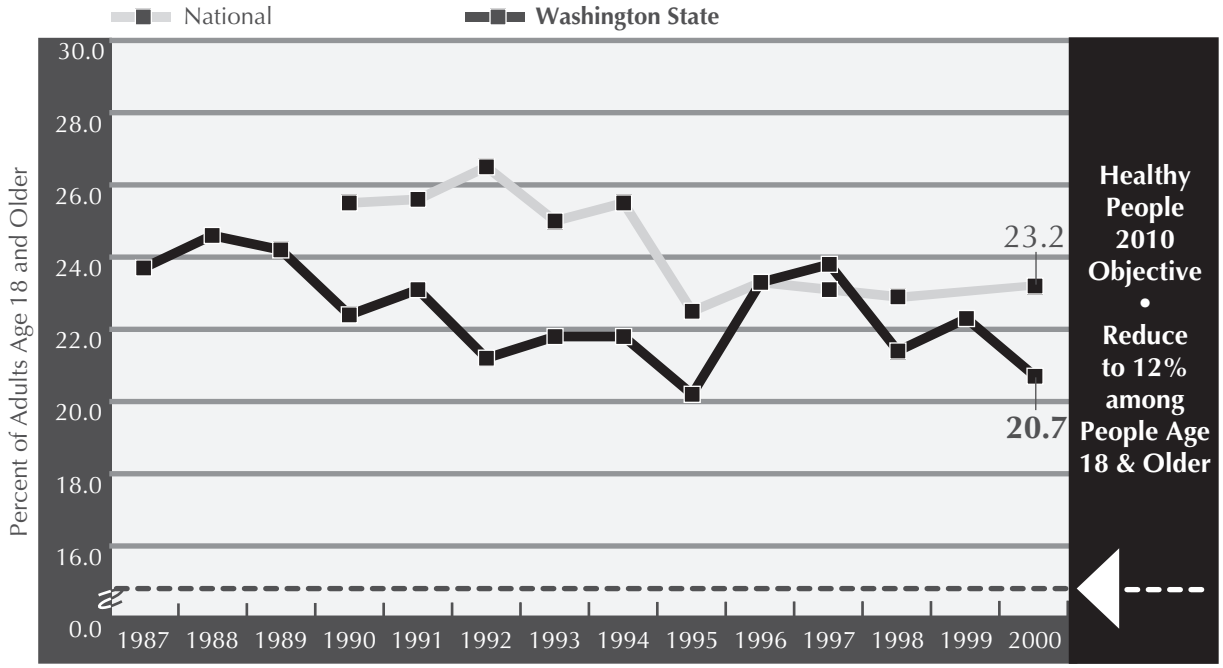
Percent of Adults in Household



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30 day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.
Note: Starred groups are "statistically" significantly different from their reference group. p<.10*, p<.05**.
**"Hard drugs" are any of the following substances used for non-medical purposes: sedatives, heroin, stimulants, hallucinogens, and other opiates.

A Lower Percentage of Adults in Washington State Report Being Smokers than Adults Nationally.

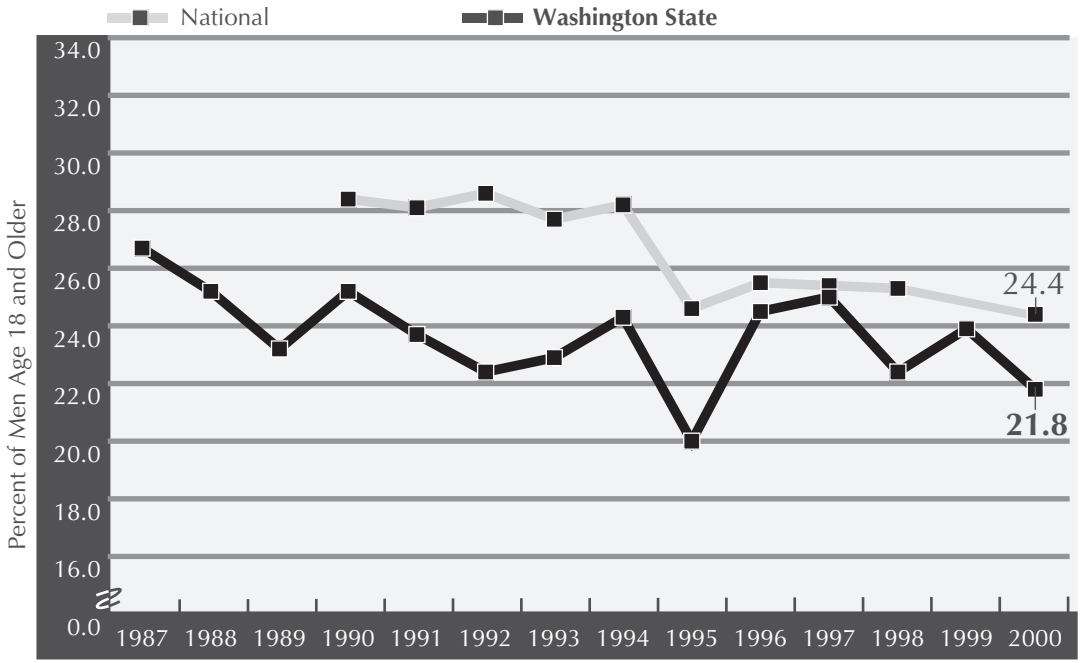


Source: Behavioral Risk Factor Surveillance System. National Center for Chronic Disease Prevention and Health Promotion.

This graph indicates that adult smoking rates in Washington are lower than the national average. According to the Surgeon General, tobacco use remains the leading cause of preventable death and disease in the United States. Since the release of the first Surgeon General's report on smoking and health, about ten million Americans have died from smoking-related diseases, including heart disease, lung cancer, emphysema, and other respiratory diseases.[1]

[1] U.S. Department of Health and Human Services. (2000). Reducing tobacco use: A report of the Surgeon General. Atlanta, GA.

Smoking Prevalence Among Men in Washington State is Lower than That Reported Among Men Nationally.

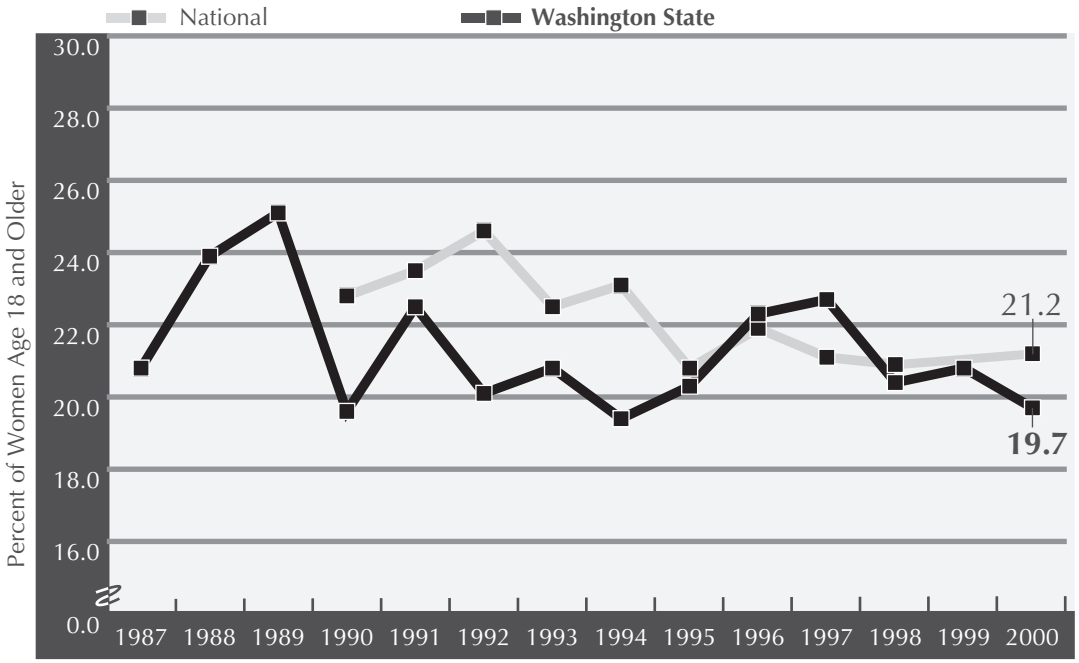


Source: Behavioral Risk Factor Surveillance System. National Center for Chronic Disease Prevention and Health Promotion.

This graph indicates that smoking prevalence among Washington men is lower than among men nationally. ***Healthy People 2010*** sets a target objective to reduce tobacco smoking by adults ages 18 and older to 12%.

No national rate is available for 1999.

Smoking Prevalence Among Women in Washington State is Lower than That Reported by Women Nationally.

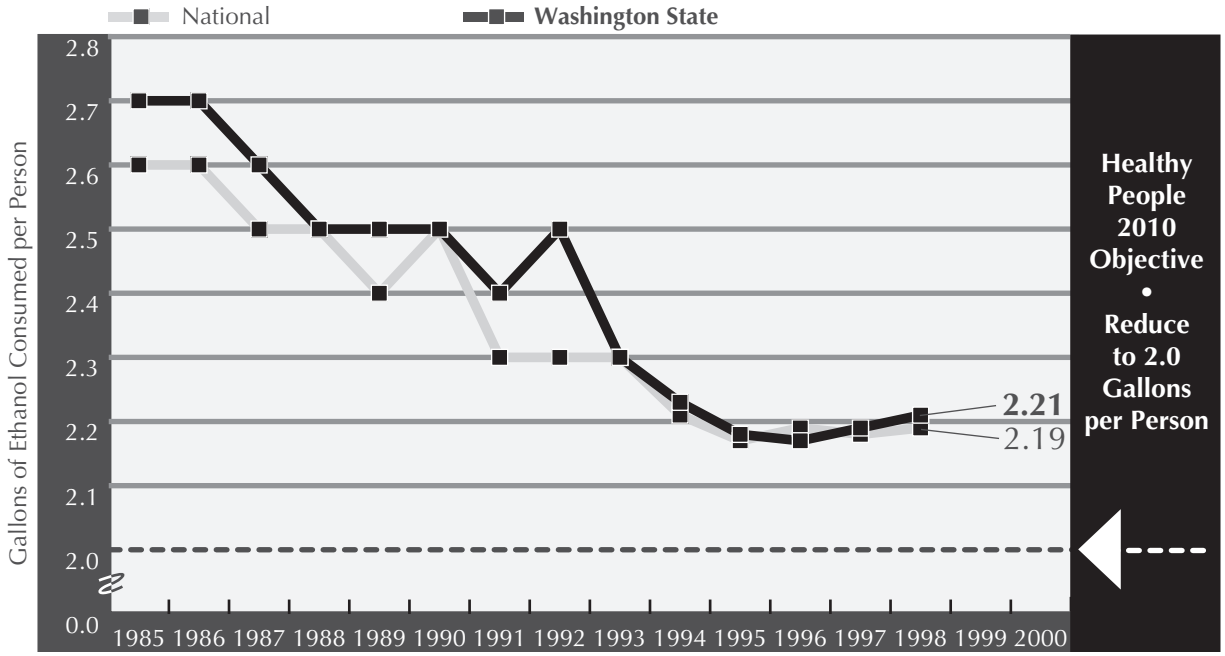


Source: Behavioral Risk Factor Surveillance System. National Center for Chronic Disease Prevention and Health Promotion.

This graph indicates that smoking prevalence among Washington women is lower than among women nationally. Smoking among women during pregnancy is of particular concern. ***Healthy People 2010*** states that evidence is accumulating indicating that maternal tobacco use is associated with mental retardation and birth defects such as oral clefts.[1]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference edition), 27-3. Washington, DC.

Per Capita Alcohol Consumption in Washington State is Similar to That of the Rest of the Nation.



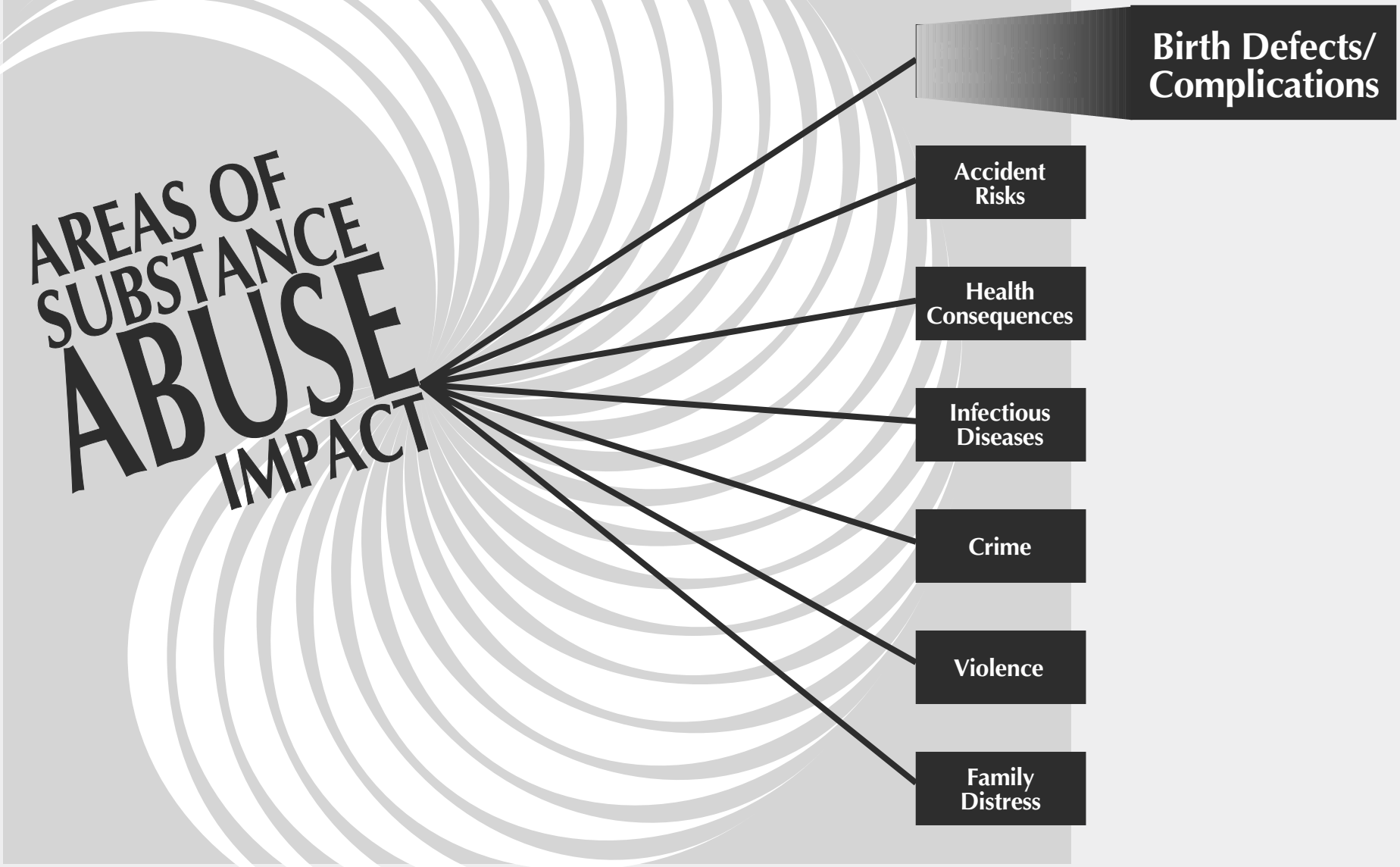
Nephew, T., Williams, G., Stinson, F., Nguyen, K., and Dufour, M. (2000). Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1977-98. (Surveillance Report #55). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

State and national data reflect consumption for all persons over age 14. However, surveys indicate alcohol consumption among youth age 14 and younger. In 2000, 21.2% of Washington sixth graders, and 45.7% of eighth graders reported that they had already tried alcohol.[1]

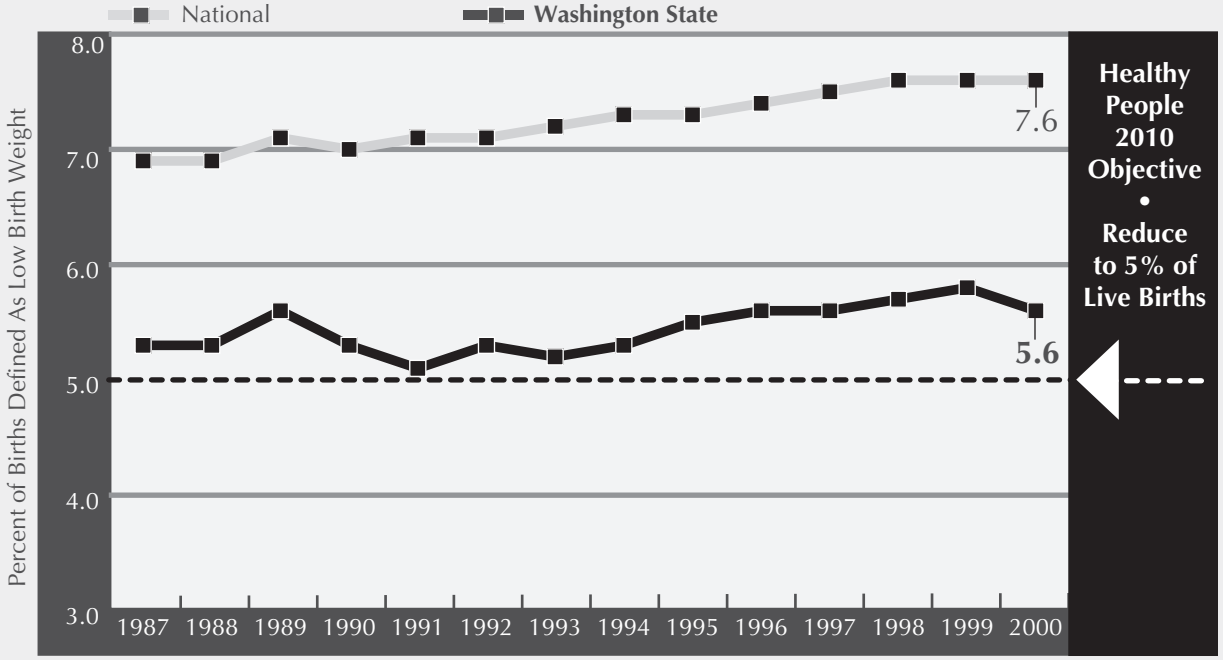
[1] Office of the Superintendent of Public Instruction. (2001). Washington state survey of adolescent health behaviors. Olympia, WA.

The Problem: Substance Abuse Prevalence & Trends

The Problem: Substance Abuse Prevalence & Trends



A Lower Percentage of Low Birth Weight Babies are Born in Washington State than Nationally.



Source: National data from the National Vital Statistics System, Centers for Disease Control and Prevention, National Center for Health Statistics. State data from Washington State Department of Health, Center for Health Statistics.

This graph indicates that the percentage of low birth weight (LBW) infants born in Washington State is lower than the national rate.

LBW infants are newborns who weigh less than 2500 grams (5 lbs. 8 ounces) and include those born too early and those whose intrauterine growth is retarded. LBW is associated with long-term disabilities, including cerebral palsy, autism, mental retardation, hearing impairments, and other developmental problems. It is also the risk factor most closely associated with neonatal deaths.[1] Smoking accounts for 20-30% of all LBW births.[2] Two Washington studies reported fewer LBW births among substance abusing women who received chemical dependency treatment during pregnancy.[3]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 16-4. Washington, DC.
[2] Ibid., 16-34.
[3] Krohn., M. (1993). Preliminary findings for MOMS project, in FOCUS. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Schrager, L., Kenny, F., and Cawthon, L. (1993). Substance abuse treatment for female DASA clients: Treatments, birth outcomes, and demographic profiles. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis.

Washington State Has a Lower Infant Death Rate than the Nation.

Source: Washington State Department of Health, Center for Health Statistics; Centers for Disease Control and Prevention, National Center for Health Statistics.

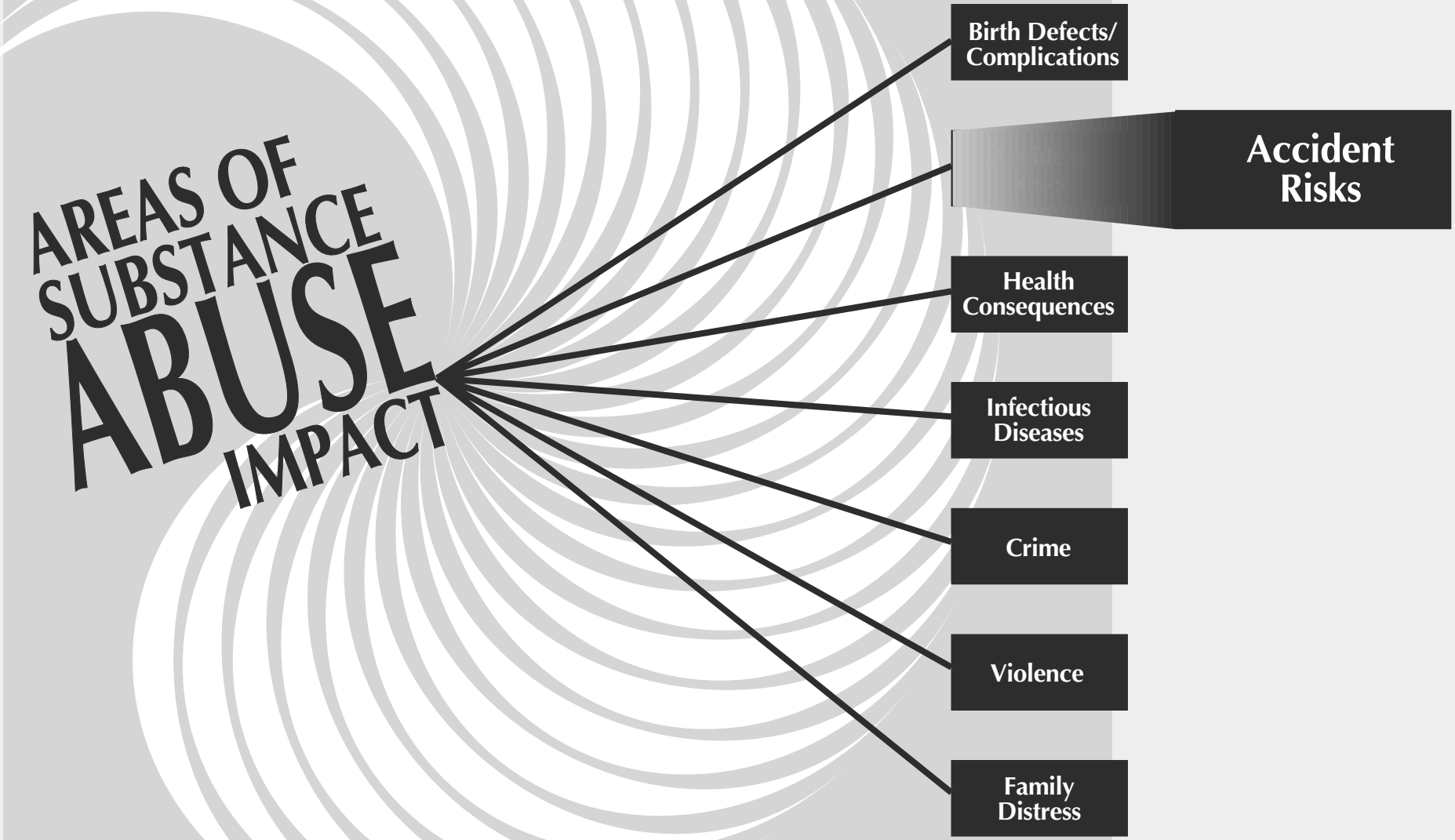
This graph indicates that Washington State has had consistently lower infant death rates than the nation. Rates in both Washington and the nation have dropped substantially in the past 15 years. However, infant death rates remain much higher than in most industrialized nations.[1]

Infant mortality rates represent the number of infants, per thousand live births, who die within their first year of life. Sudden Infant Death Syndrome (SIDS) accounts for nearly one-third of all infant deaths after the first month of life. The cause of SIDS has not been identified, though public education campaigns to ensure infants are put to sleep on their backs greatly reduce the risk of SIDS among healthy full-term infants.[2]

Nationally, ***Healthy People 2010*** reports that overall rates of alcohol use during pregnancy increased during the 1990s, and the proportion of pregnant women using alcohol at higher and more hazardous levels has increased substantially.[3] In Washington State, infant mortality rates for children born to mothers on Medicaid and identified as substance abusers are more than twice as high as those for infants born to mothers on Medicaid not so identified.[4]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 16-3. Washington, DC.
[2] Ibid., 16-38.
[3] Ibid., 16-5.
[4] First Steps Database, 1990-1997. (1999) Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis.

The Problem: Substance Abuse Prevalence & Trends



In 2000, Washington State Reported a Lower Rate of Motor Vehicle Fatalities Related to Alcohol than the Nation.

Source: National Highway Traffic Safety Administration, Fatality Analysis Reporting System.

This graph indicates that the Washington State alcohol-related motor fatality rate has remained below the national rate since 1991.

Lower fatality rates are associated with increased use of safety restraints, enforcement of minimum drinking age and zero tolerance laws, and statutes setting lower blood alcohol concentration (BAC) standards for driving while intoxicated.[1] Of particular concern is the fatality rate among American Indians and young people ages 15-24. In 1994, the fatality rate for American Indian (including Alaskan native) males in alcohol-involved traffic crashes was four times higher than for the general population. The alcohol-related traffic fatality rate for youth is also very high, but has dropped more than 50% since 1982, mostly as a result of enforcement of minimum drinking age laws.[2]

[1]National Highway Traffic Safety Administration, National Center for Statistics & Analysis, Research and Development. (2001). Traffic safety facts 2000-Alcohol. Washington, DC: U.S. Department of Transportation. National Highway Traffic Safety Administration. Promoting safe passage into the 21st century – Strategic plan 1998. Washington, DC: U.S Department of Transportation.
[2] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 26-14. Washington, DC.

The Death Rate from Alcohol-Related Motor Vehicle Crashes per 100 Million Miles Traveled Has Dropped Substantially Over the Last 15 Years, Both in Washington State and Nationally.

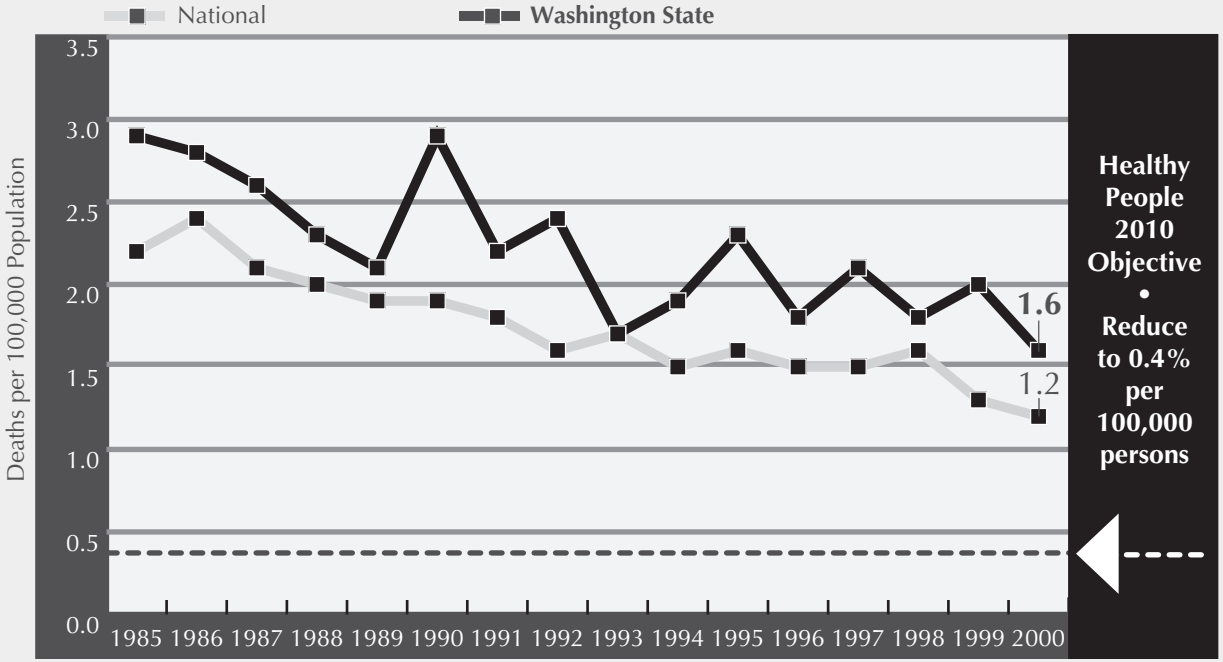
Source: National Highway Traffic Safety Administration, Fatality Analysis Reporting System

This graph indicates that the rate in Washington State of alcohol-related motor vehicle deaths per 100 million vehicle miles traveled has been at or below the national rate since 1991.

In 2000, the motor vehicle fatality rate per 100,000 vehicle miles of travel reached an historic low. Lower fatality rates are associated with increased use of safety restraints, enforcement of minimum drinking age and zero tolerance laws, and statutes setting lower blood alcohol concentration (BAC) standards for driving while intoxicated.[1] The National Highway Traffic Safety Administration estimates that since 1975, over 17,300 lives have been saved by enforcement of minimum drinking age laws.[2]

[1] National Highway Traffic Safety Administration, National Center for Statistics & Analysis, Research and Development. (2001). Traffic safety facts 2000--Alcohol. Washington DC: U.S. Department of Transportation. National Highway Traffic Safety Administration. Promoting safe passing into the 21st century – Strategic plan 1998. Washington DC: U.S. Department of Transportation.
[2] National Highway Traffic Safety Administration. 1996 youth fatal crash and alcohol facts. Washington, DC: U.S. Department of Transportation.

Washington State Has a Higher Rate of Deaths Due to Drowning than the Nation.



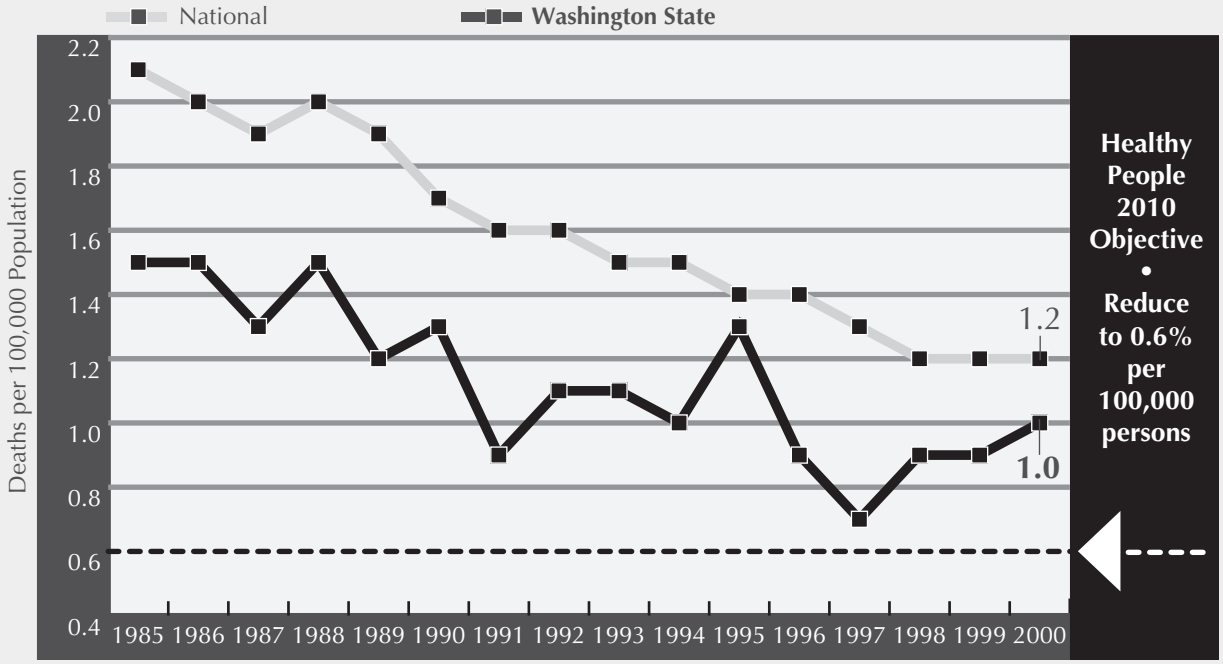
Source: Washington State Department of Health, Center for Health Statistics; Centers for Disease Control and Prevention, National Center for Health Statistics.

This graph indicates that the rate of drowning deaths in Washington State has been consistently higher than the national rate. There were 92 drowning deaths in Washington State in 2000. Nationally, drowning is the second leading cause of injury-related death for children and adolescents ages 1-19.[1]

The total number of drowning deaths attributable to alcohol or drug use in Washington State is not currently available. However, on a national level, alcohol is involved in approximately 50% of deaths associated with water recreation.[2]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 15-40. Washington, DC.
[2] Ibid.

Washington State Has Had a Lower Rate of Deaths Due to Residential Fires than the Nation for More Than a Decade.

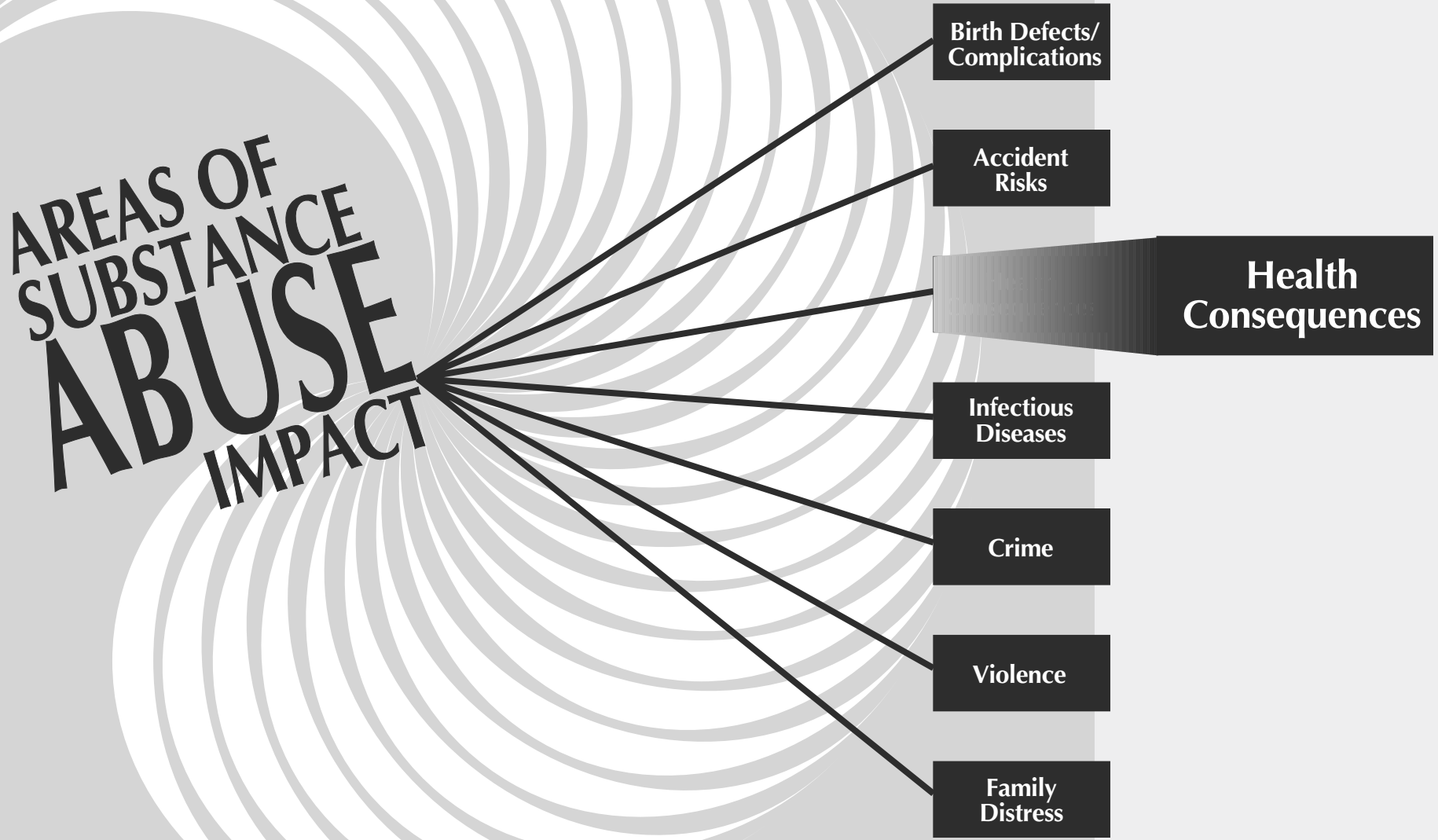


Source: Washington State Department of Health, Center for Health Statistics; Centers for Disease Control and Prevention, National Center for Health Statistics.

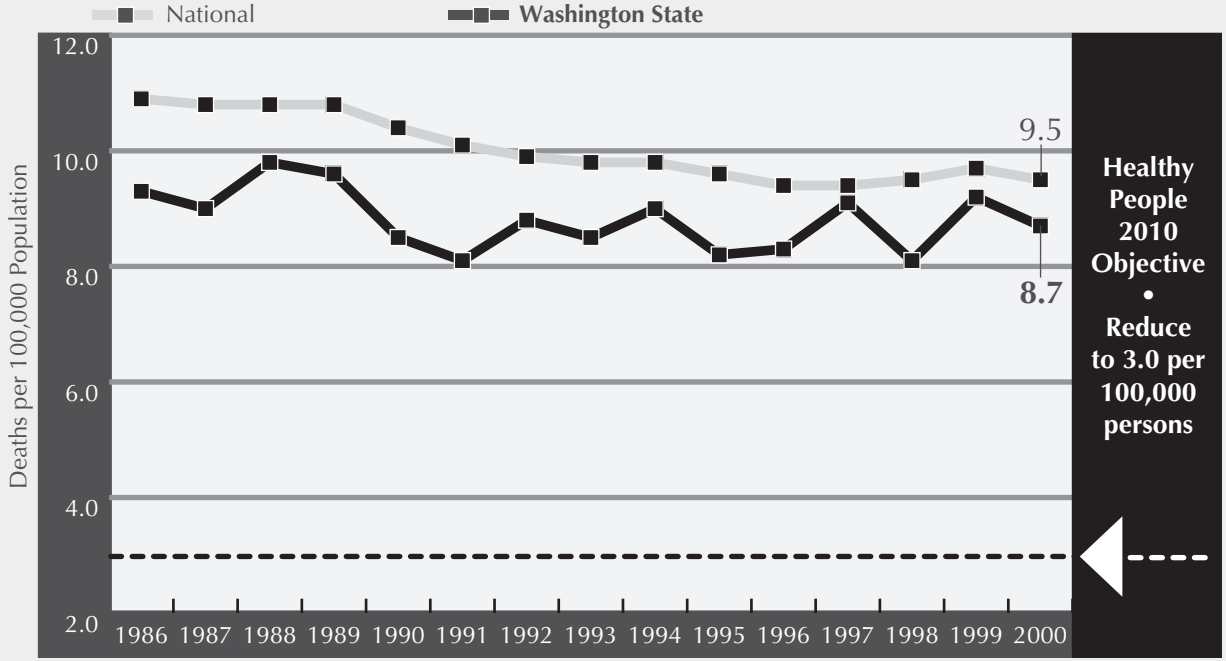
This graph indicates that Washington State has a consistently lower death rate from residential fires than the United States. From 1993 to 1997, Washington State averaged 53 deaths annually due to residential fires. Some 30% of these deaths were among those age 65 or older, and 24% were under age 10.[1] The installation of smoke alarms can reduce the risk of dying in a residential fire in half.[2]

[1] National Center for Health Statistics. (1999). Washington Injury Mortality Statistics and United States Injury Mortality Statistics.
[2] Runyan, C., Bangdiwala, S., Linzer, M., Sacks, J., & Butts. J. (1992). Risk factors for fatal residential fires. New England Journal of Medicine 327(12), 859-863.

The Problem: Substance Abuse Prevalence & Trends



Washington State Has a Lower Rate of Deaths Due to Chronic Liver Disease and Cirrhosis than the Nation.



Source: National Vital Statistics System, Centers for Disease Control and Prevention, National Center for Health Statistics.

This graph indicates that the death rate due to chronic liver disease and cirrhosis in Washington State is lower than the nation as a whole. In 2000, liver disease including cirrhosis was the tenth leading cause of death in Washington. Cirrhosis occurs when healthy liver tissue is replaced with scarred tissue until the liver is unable to function effectively. Sustained heavy alcohol consumption is the leading cause of cirrhosis.

[1] Washington State Department of Health, Center for Health Statistics (2001).
[2] U.S. Department of Health and Human Services (2000). Healthy people 2010 (Conference Edition), 26-16. Washington, DC.

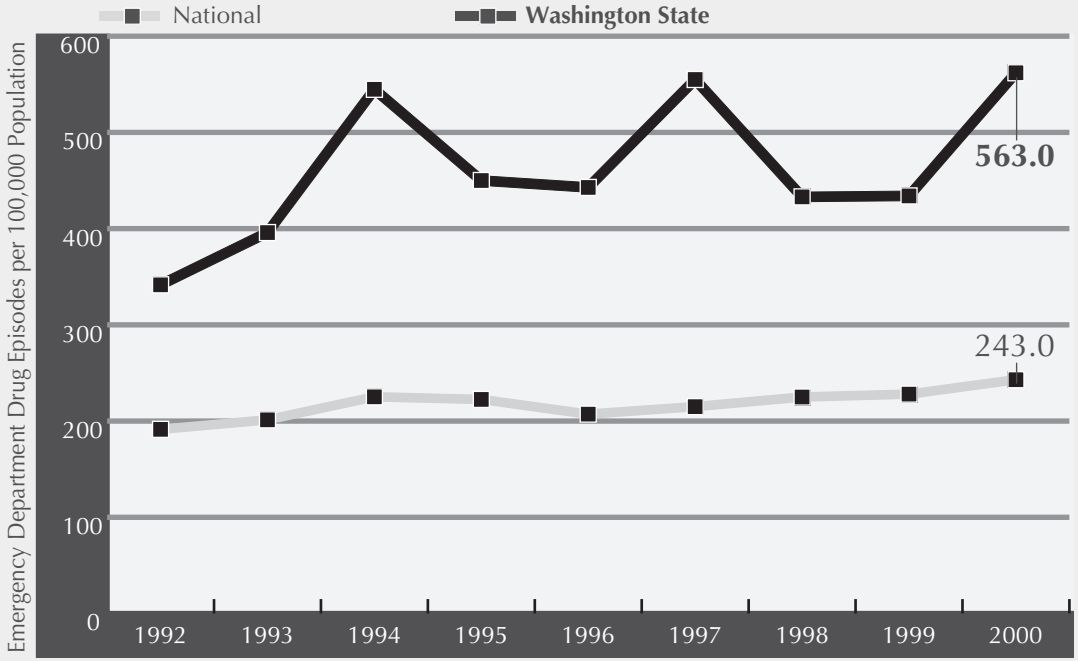
The Drug-Induced Death Rate in Washington State is More than Double What It was in 1991.

Source: National Vital Statistics System, Centers for Disease Control and Prevention, National Center for Health Statistics.

This graph indicates that Washington State had had a consistently higher drug-induced death rate than the nation. This rate is more than twice as high as it was in 1991.

Drug-related death data provide a direct indication of the high human and social costs of drug use. Causes of death classified as drug-related include drug psychosis, drug dependence, suicide, and intentional and unintentional poisoning resulting from illicit drug use.

The Seattle Metropolitan Area Has a Higher Rate of Drug-Related Emergency Room Visits than the Nation.

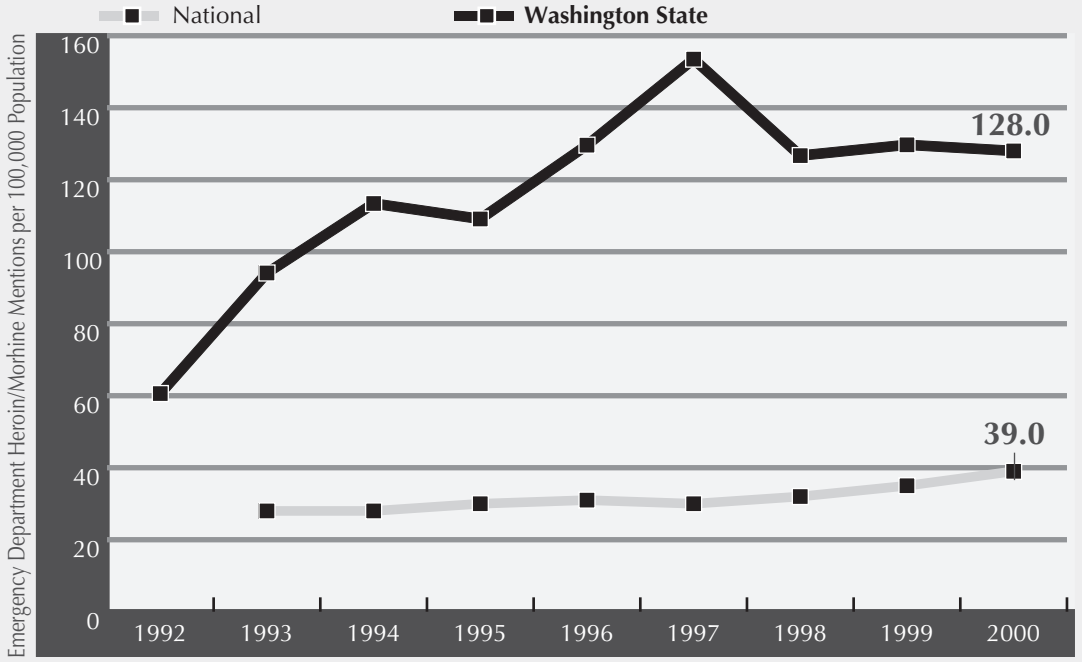


Source: National and state data from the Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (DAWN).

This graph indicates that the Seattle metropolitan area (the only area in Washington State for which this information is available) has a higher rate than the nation for drug-related emergency room visits.

The federal Drug Abuse Warning Network (DAWN) defines an emergency department visit as drug-related whenever the visit is a result of the non-medical use of a drug. Non-medical drug use includes use of illicit drugs, use of prescription drugs in a manner inconsistent with accepted medical practice, and the use of over-the-counter drugs contrary to approved labeling.

Rates of Emergency Department Mentions of Heroin/Morphine in Seattle-King County Have Stabilized Since 1997.



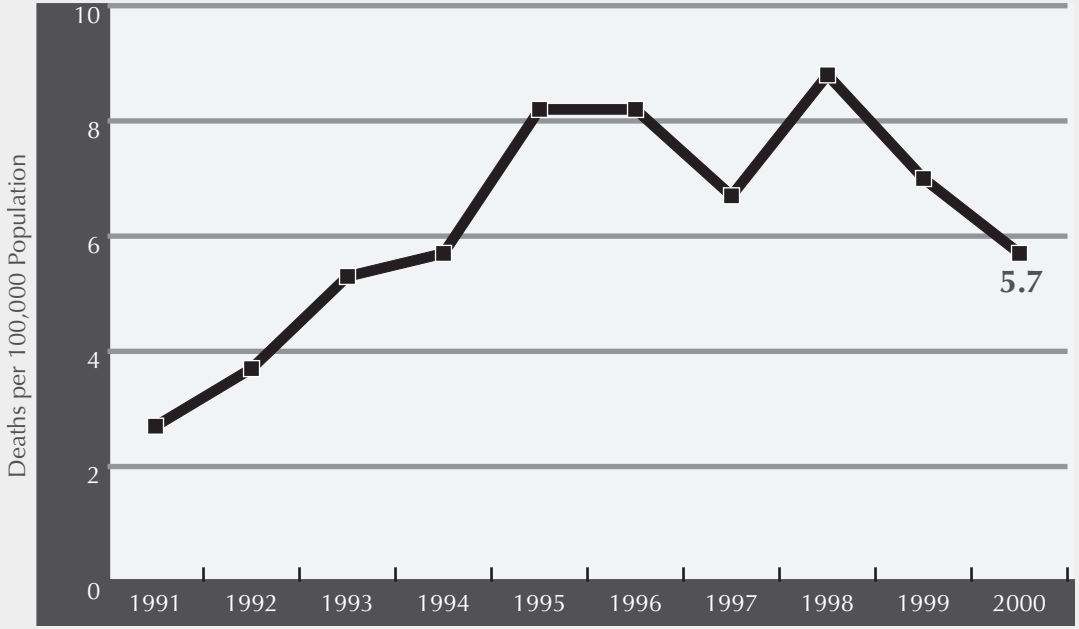
Source: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network (DAWN).

This graph indicates that after doubling between 1992 and 1997, the steep rise in emergency department mentions of heroin/morphine in Seattle-King County has been leveling off. This rate is paralleled by the decline in the number and rate of heroin-related deaths.

Some of this decline may be due to increases in treatment capacity for individuals with heroin addiction. However, there are still substantial waiting lists for publicly funded methadone treatment in King County, and throughout the state. At the Seattle needle exchange program, there is now a list of more than 500 individuals awaiting treatment for heroin addiction.[1]

[1]Heroin Task Force Report, Public Health – Seattle & King County. (August 2001). Confronting the problem of heroin abuse in Seattle and King County.

Rates of Heroin-Related Deaths in Seattle-King County Have Declined Recently, After Rising Rapidly Through 1998.



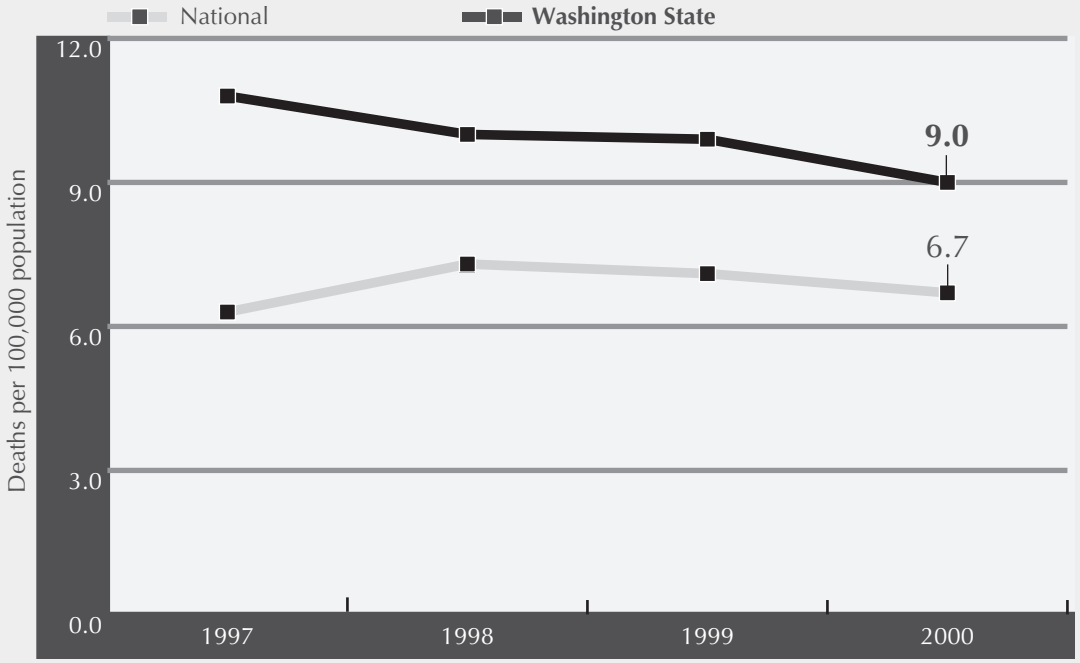
Source: King County Medical Examiner.

This graph indicates that while the rate of heroin-related drug-caused deaths in Seattle-King County increased fourfold from 1991-1998, they have declined by more than 30% since then, from a total of 143 deaths in 1998 to 99 in 2000.[1]

Since 1999, public health measures have been adopted by city and county governments to address heroin addiction. King County authorized a 50% expansion in the number of methadone treatment slots, and authorized a mobile methadone clinic. The number of treatment admissions for heroin increased from 1,140 in 1998 to 2,101 in 2000. They have also provided preventive and limited substance-abuse treatment services in the local criminal justice system, and expanded the availability of drug-free housing for individuals in recovery.

[1] Community Epidemiology Work Group. (June 2001). Recent drug abuse trends in the Seattle-King County area. Bethesda, MD: National Institutes of Health, National Institute on Drug Abuse.

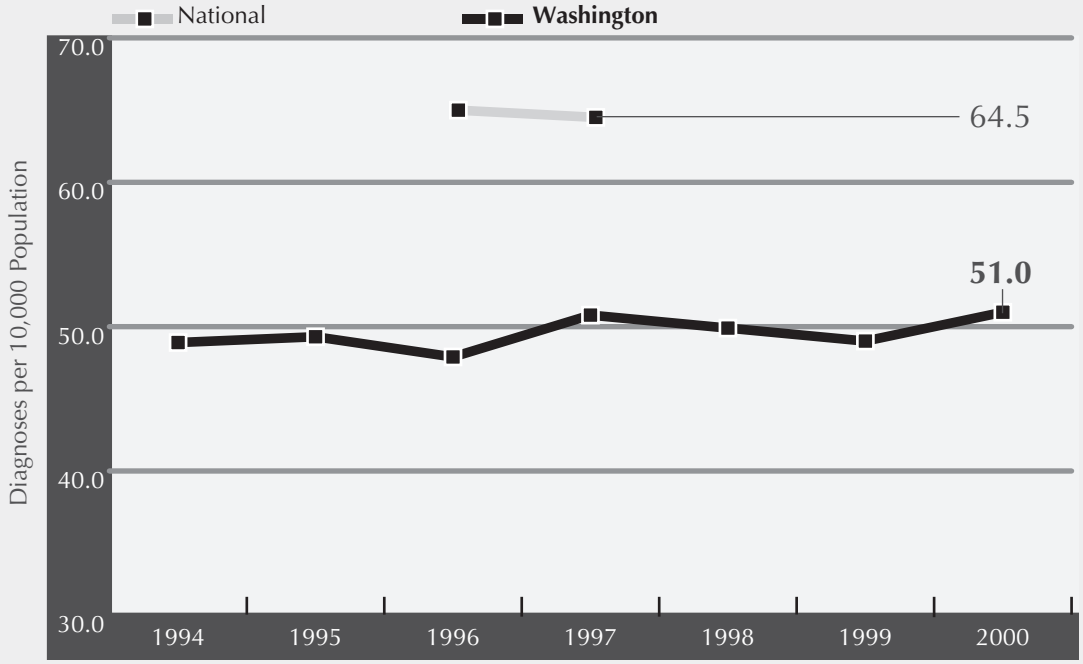
Washington State Has a Higher Alcohol-Induced Death Rate than the Nation.



Source: National Vital Statistics System, Centers for Disease Control and Prevention, National Center for Health Statistics

This graph indicates that Washington State has had a consistently higher alcohol-induced death rate than the nation. It should be noted that the alcohol-induced death rate in Washington State is consistently higher than the drug-induced death rate. Alcohol-related death data provide a direct indication of the high human and social costs of alcohol use.

The Rate of Alcohol-Related Diagnoses Among Acute Hospital Discharges Has Remained Static for the Past Seven Years.



Source: National data from the National Institute on Alcohol Abuse and Alcoholism, Surveillance Report #50: Trends in Alcohol-Related Morbidity Among Short Stay Community Hospital Discharges, United States, 1979-97. State data from the Office of Hospital and Patient Data Systems, Comprehensive Hospital Abstract Reporting System, Washington State Department of Health.

Alcohol related diagnoses are defined as discharges from acute care hospitals associated with primary alcohol-related conditions such as alcoholic psychoses, alcohol dependence syndrome, nondependent abuse of alcohol, and chronic liver disease and cirrhosis. They do not include alcohol-related trauma such as injuries from alcohol-related motor vehicle accidents, or discharges associated with maternity stays. There were 23,672 primary alcohol-related diagnoses discharges from Washington State hospitals in 2000.

The Rate of Lung Cancer Deaths in Washington Exceeds the National Rate.

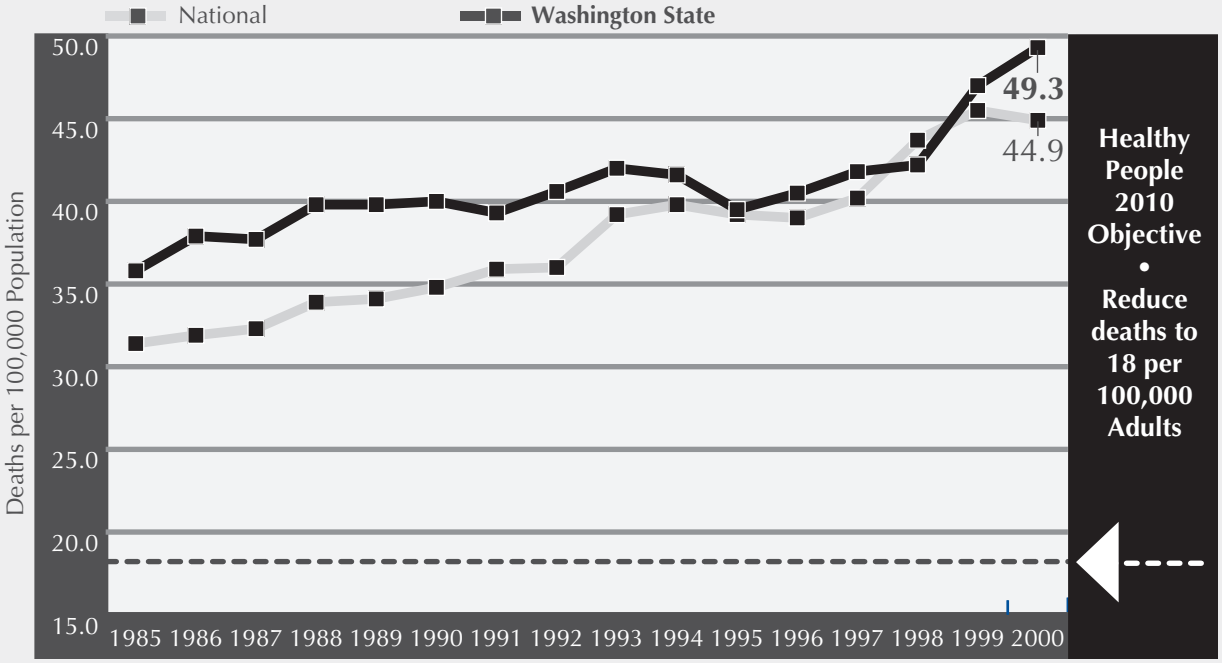
Source: Washington State Department of Health, Center for Health Statistics; Centers for Disease Control and Prevention, National Center for Health Statistics

This graph indicates that the rate of deaths from lung cancer in Washington State has now risen above the national rate. Lung cancer is the most common cause of cancer mortality in the U.S.

The vast majority of lung cancer cases are attributable to cigarette smoking, accounting for 68-78% of lung cancer deaths among females and 88-91% of such deaths among males. Smoking cessation decreases the risk of lung cancer to 30-50% of that of continuing smokers after 10 years of abstinence.[1]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 3-12. Washington, DC.

Washington State's Death Rate from Chronic Lower Respiratory Disease is Rising and Exceeds the National Rate.

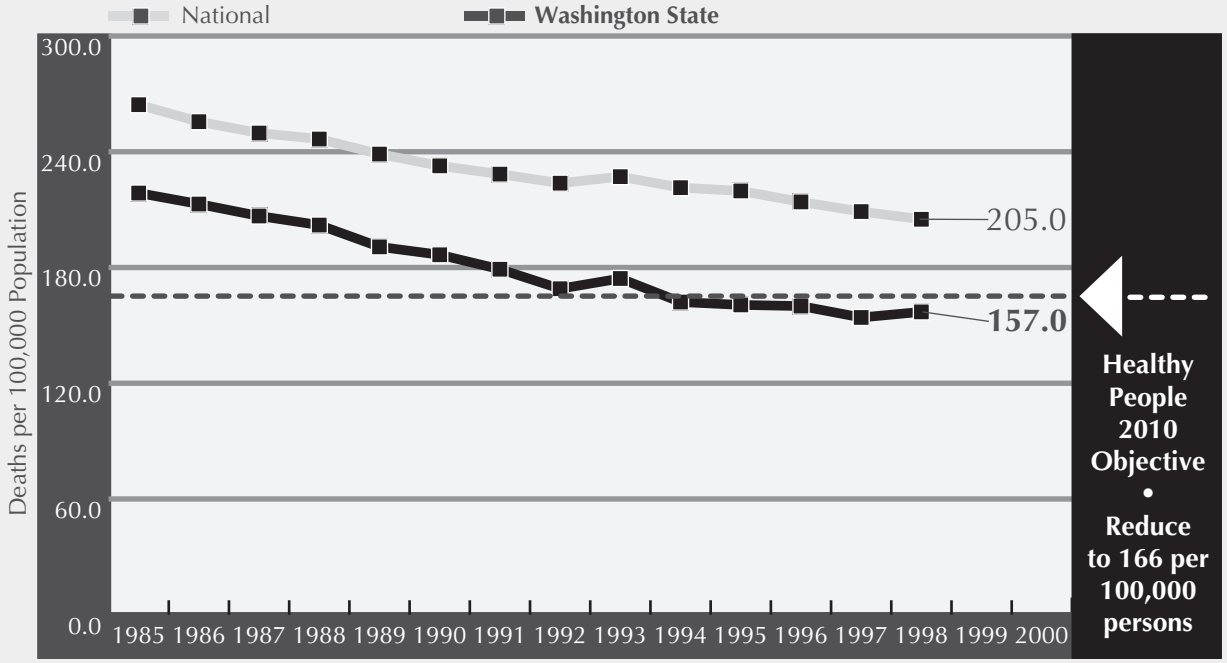


Source: Washington State Department of Health, Center for Health Statistics; Centers for Disease Control and Prevention, National Center for Health Statistics

This graph indicates that the mortality rate from chronic lower respiratory disease (formerly known as chronic obstructive pulmonary disease) in Washington State is rising, and for the last two years has exceeded the national rate. Chronic lower respiratory disease includes chronic bronchitis and emphysema, both of which are characterized by irreversible airflow obstruction and often exist together. This disease occurs most often in people over age 65. Between 80-90% of chronic lower respiratory disease is attributable to cigarette smoking.[1]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 24-8. Washington, DC.

The Death Rate from Coronary Heart Disease in Washington State is Lower than the Nation.



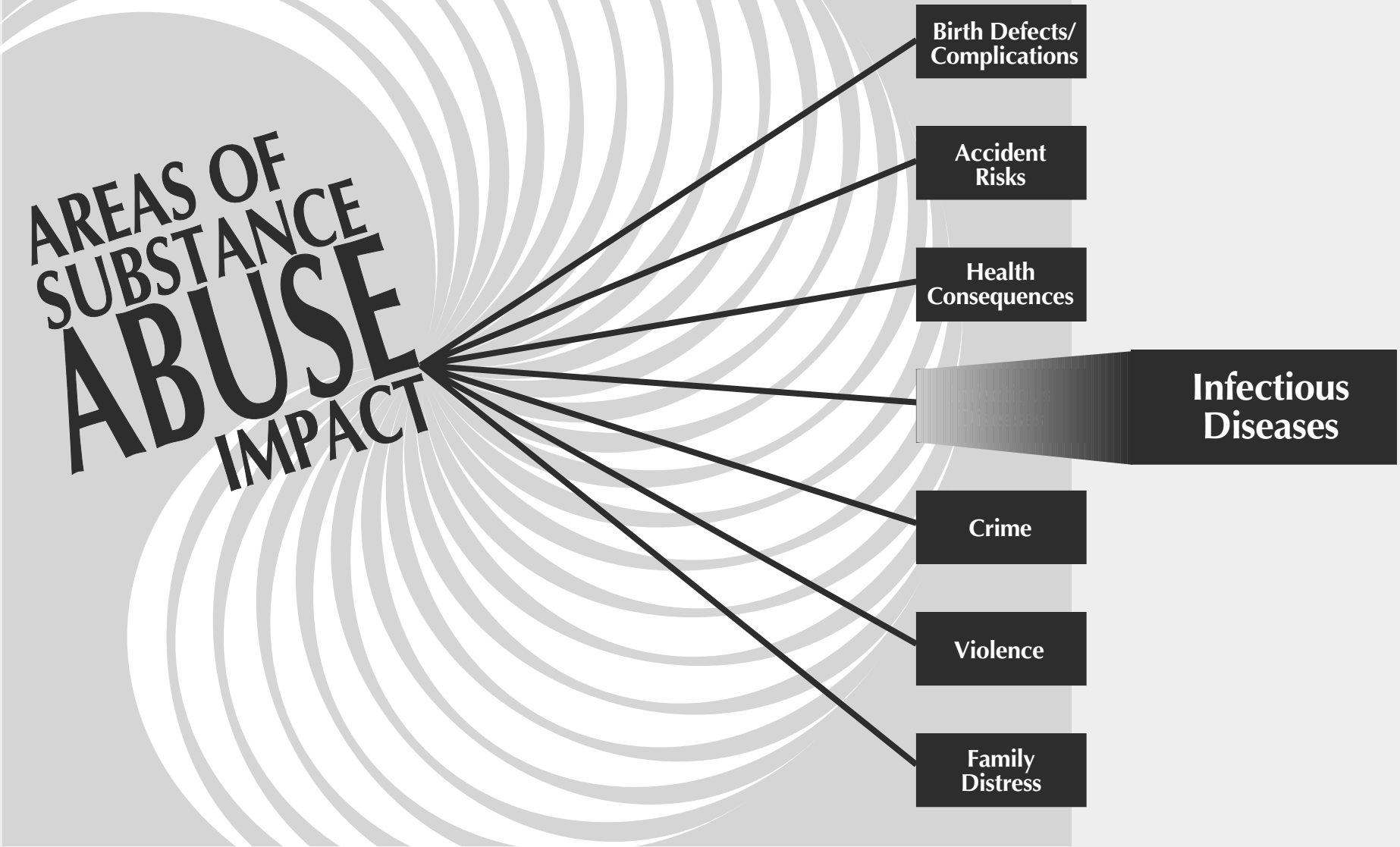
Source: Centers for Disease Control and Prevention, National Center for Health Statistics

This graph indicates that the rate of death from coronary heart disease in Washington is consistently lower than the national rate, and is below the ***Healthy People 2010*** target objective.

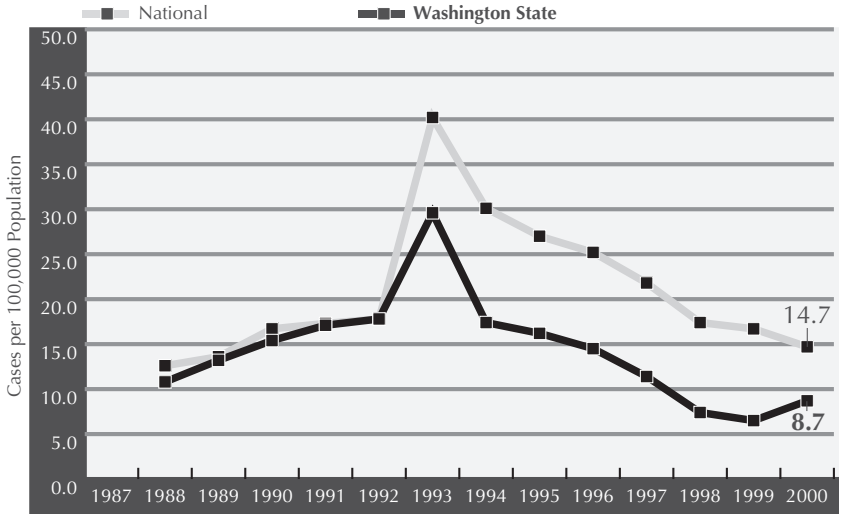
Heart disease is the leading cause of death in the U.S., and coronary heart disease accounts for the largest portion of heart disease. About 12 million Americans have coronary disease. Prevention strategies including reducing high blood cholesterol, high blood pressure, excessive weight gain, and cigarette smoking, as well as increasing amounts of physical activity.[1]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 12-6. Washington, DC.

The Problem: Substance Abuse Prevalence & Trends



The Reported AIDS Case Rate in Washington State is Lower than the Nation.*



Source: National data from the Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, 2001. State data from the Washington State Department of Health, Office of HIV Prevention and Education.

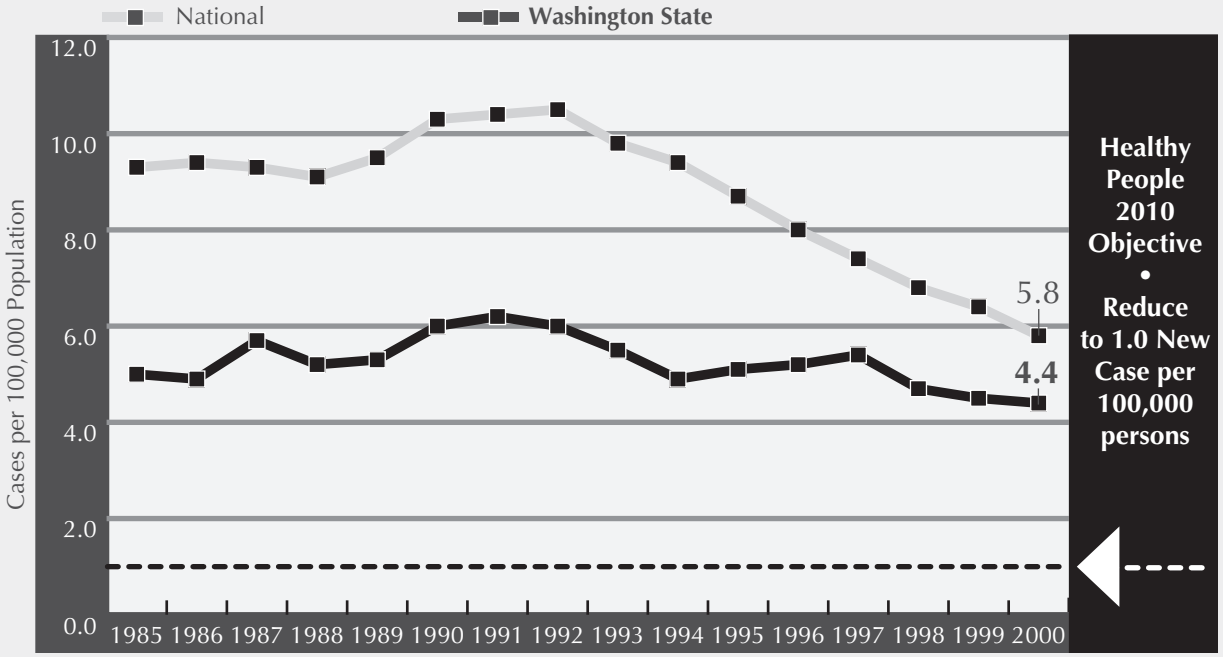
This graph indicates that the reported AIDS case rate in Washington State is consistently lower than the nation's. The human immunodeficiency virus (HIV), which is the cause of acquired immunodeficiency syndrome (AIDS), is transmitted through blood and other bodily fluids. Since 1993, the AIDS case rate had been in decline, reflecting the effectiveness of new treatments in preventing HIV infection from progressing to AIDS. However, the recent increase in the AIDS case rate in Washington State likely reflects the growing failure of anti-retroviral medications to work for more than five years, as well as larger numbers of individuals seeking treatment now that medications are available.[1]

From 1982 through October 2001, 9,825 AIDS cases were reported in Washington State, and there were 5,492 deaths from the disease.[2] From 1982-2001, 19% of diagnosed AIDS cases in Washington State were traceable to possible exposure from injection drug users (IDUs). Nationally, about two-thirds of new HIV infections each year are attributed to injection drug use.[3] Studies have shown that cities that implemented needle exchange programs early in the AIDS epidemic have much lower infection rates among IDUs. Seattle, which implemented needle exchange rates early, has a 2-4% IDU seroconversion rate.** New York and Miami, which waited to implement them, have 40-60% IDU seroconversion rates.[4]

** Case counts are provisional; reporting is considered incomplete for several years.*
***Percentage of IDUs where blood tests indicate presence of HIV infection.*

[1] Washington State Department of Health, Infectious Disease and Reproductive Health Assessment Unit, (2001).
[2] Washington State Department of Health, Office of HIV Prevention and Education, (2001).
[3] Disease prevention fact sheet: needle exchange. (1997). Seattle, WA: Seattle-King County Department of Public Health.
[4] Letter to Senator Patty Murray, (June 2, 1999). Olympia, WA: Washington State Board of Health.

Washington State Has Had a Consistently Lower Rate of New Tuberculosis Cases than the Nation for More than a Decade.



Source: National data from the Centers for Disease Control and Prevention, Summary of Notifiable Diseases. State data from the Washington State Department of Health, Assessment Unit – Infectious Disease and Reproductive Health, Tuberculosis Epidemiologic Profile, 2001.

This graph indicates that Washington has had a consistently lower tuberculosis rate than the nation. After a national and state resurgence in the early 1990s, the tuberculosis epidemic appears to be receding.

Multiple factors including poverty, homelessness, substance abuse, gaps in health care infrastructure, and the human immunodeficiency virus (HIV) epidemic are associated with new tuberculosis cases. Assuring that patients with active tuberculosis infection complete curative therapy early is essential to curbing the disease's spread. ***Healthy People 2010*** sets a target objective of 90% for the percentage of all tuberculosis patients who complete curative therapy within 12 months of diagnosis.

Washington State has adopted treatment provider regulations to screen all chemical dependency treatment patients for tuberculosis to help prevent and control the spread of the disease in the state.

The Rate of Hepatitis B in Washington State Has Declined Sharply in the Past 15 Years.

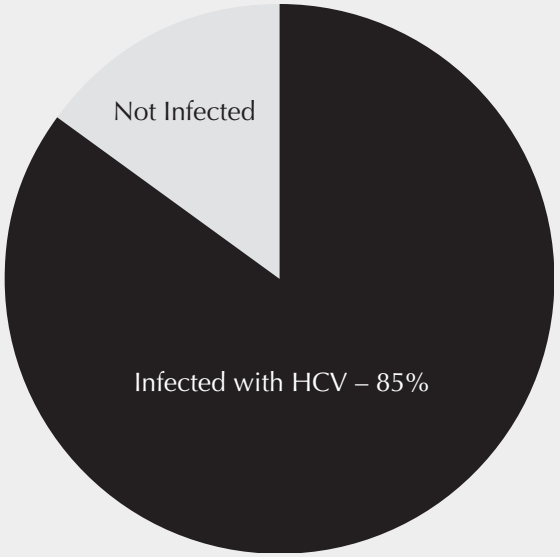
Source: National data from the National Notifiable Disease Surveillance System, Centers for Disease Control and Prevention, Epidemiology Program Office. State data from the Washington State Department of Health, Annual Communicable Disease Report 2000.

This graph indicates that the rate for acute hepatitis B cases in Washington State is below that of the nation, and has declined sharply in the past 15 years. (Only acute cases are currently reportable in Washington.) Hepatitis B is a serious disease that attacks the liver and is associated with cirrhosis, liver cancer, and liver failure. It is transmitted through blood, blood products, and sexual fluids. The hepatitis B virus (HBV) may be carried chronically without sign of infection, and transmitted perinatally. There is now a routine childhood vaccination for HBV.

Injection drug use is a major risk factor for hepatitis B infection. Most cases occur in young adult risk groups, including persons with a history of multiple sex partners, men who have sex with men, injection drug users, incarcerated persons, and household and sex contacts of infected persons.[1] A 1992 study also noted a higher rate of hepatitis B infection among alcoholics.[2]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 14-15. Washington, DC.
[2] Rosman, A.S. (1992). Viral hepatitis and alcoholism. Alcohol Health and Research World, 16(1), 48-56.

Some 85% of Injection Drug Users in King County are Infected with Hepatitis C Virus (HCV).



Source: Community Epidemiology Work Group, Recent Drug Use Trends in the Seattle-King County Area, June 2001. National Institutes of Health, National Institute on Drug Abuse.

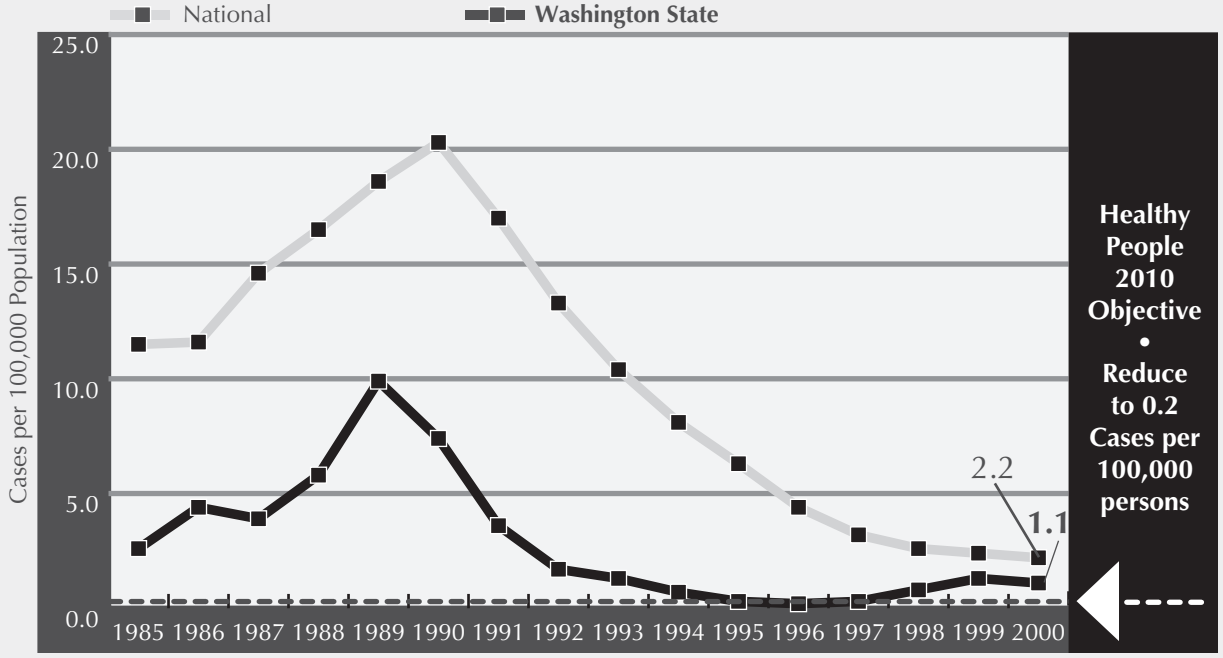
Hepatitis C virus (HCV) is the most common chronic bloodborne viral infection in the U.S. It is most commonly transmitted through repeated exposures to blood. Most new cases occur among adults ages 20-39.

The number of acute cases of hepatitis C both in Washington State and nationally remains low, at or below one case per 100,000 population. However, chronic HCV affects an estimated 2.7 million people in the U.S. and causes an estimated 8,000-10,000 deaths each year in the U.S. from cirrhosis and liver cancer.[1] It is the leading reason for liver transplantation in the U.S. and in Washington State.[2] Even moderate alcohol use is known to exacerbate liver injury resulting from HCV.

Of the 10,000-15,000 injection drug users (IDUs) in Seattle-King County, 85% are infected with HCV. Recent incidence studies indicate that 21% of non-infected Seattle-area IDUs acquire HCV each year.[3] New research indicates that HCV may paradoxically increase methadone dose requirements for those receiving opiate substitution treatment.[4]

[1] Centers for Disease Control and Prevention. (1998). Recommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease. Morbidity and Mortality Weekly, 47(RR-19).
[2] Melcrhreit, R. et al. (2001). Prevalence of hepatitis C virus infection among clients of HIV counseling and testing sites – Connecticut, 1999. Morbidity and Mortality Weekly, 50(27); 577-581.
[3] Community Epidemiology Work Group. (2001). Recent drug use trends in the Seattle-King County area, June 2001. Bethesda, MD: National Institutes of Health, National Institute on Drug Abuse.
[4] Clinical Concepts – HCV paradoxically increases methadone dose requirement. Addiction Treatment Forum, 9(4), Fall 2000.

While Lower than the Nation, Washington State Has Experienced a Substantial Increase in the Rate of Primary and Secondary Syphilis.



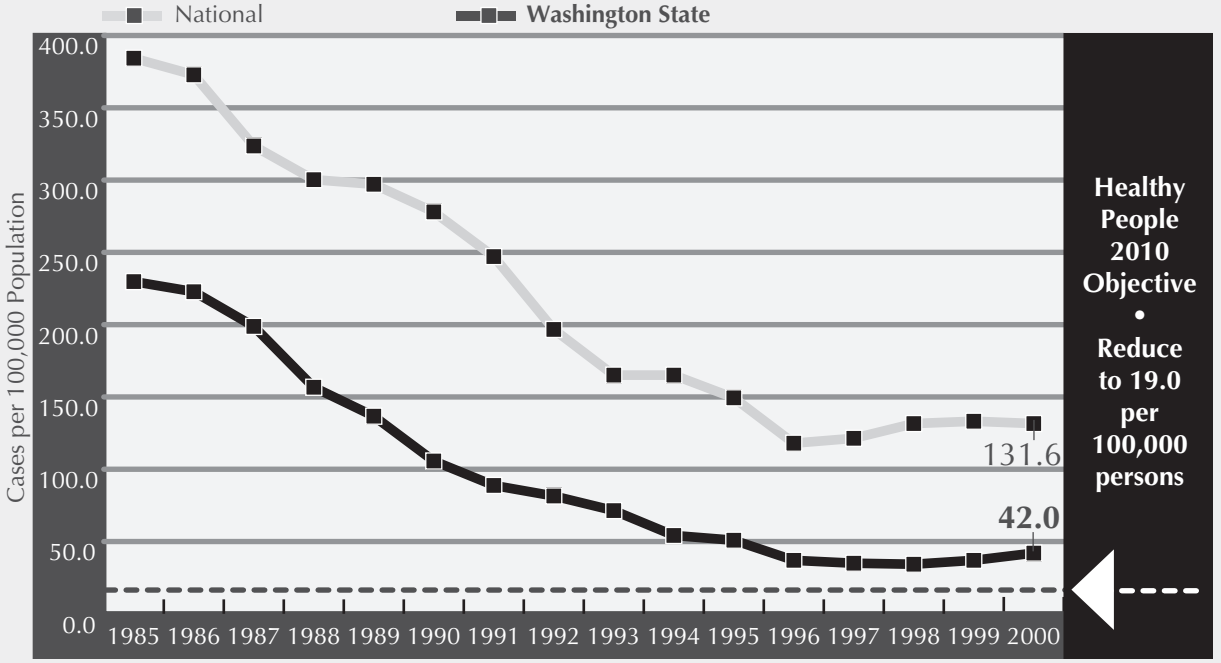
Source: National data from STD Surveillance System, Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Sexually Transmitted Disease Surveillance (2000). State data from the Washington State Department of Health, Annual Communicable Disease Report, 2000.

This graph indicates that after reaching a low of nine cases in 1996, Washington State has experienced a substantial increase in the rate of primary and secondary syphilis. There were 66 cases in 2000. This, however, significantly understates the problem, as cases are often diagnosed after they have gone beyond the primary and secondary stages and become latent. Latent cases are not incorporated in either state or national data. King County experienced a syphilis epidemic beginning in 1998, with 88 diagnosed cases, mostly among men having sex with men.[1]

The spread of sexually transmitted disease is often linked to the use or abuse of alcohol and other drugs, and can lead to epidemic spread.[2]

[1] Centers for Disease Control and Prevention. (1999). Resurgent bacterial sexually transmitted disease among men who have sex with men – King County, Washington, 1997-1999. Morbidity and Mortality Weekly 48(35); 773-777.
[2] U.S. Department of Health and Human Services. (2000) Healthy people 2010 (Conference Edition), 25-5. Washington, DC.

Gonorrhea Rates in Washington State Have Declined More than 80% in the Past 15 Years.

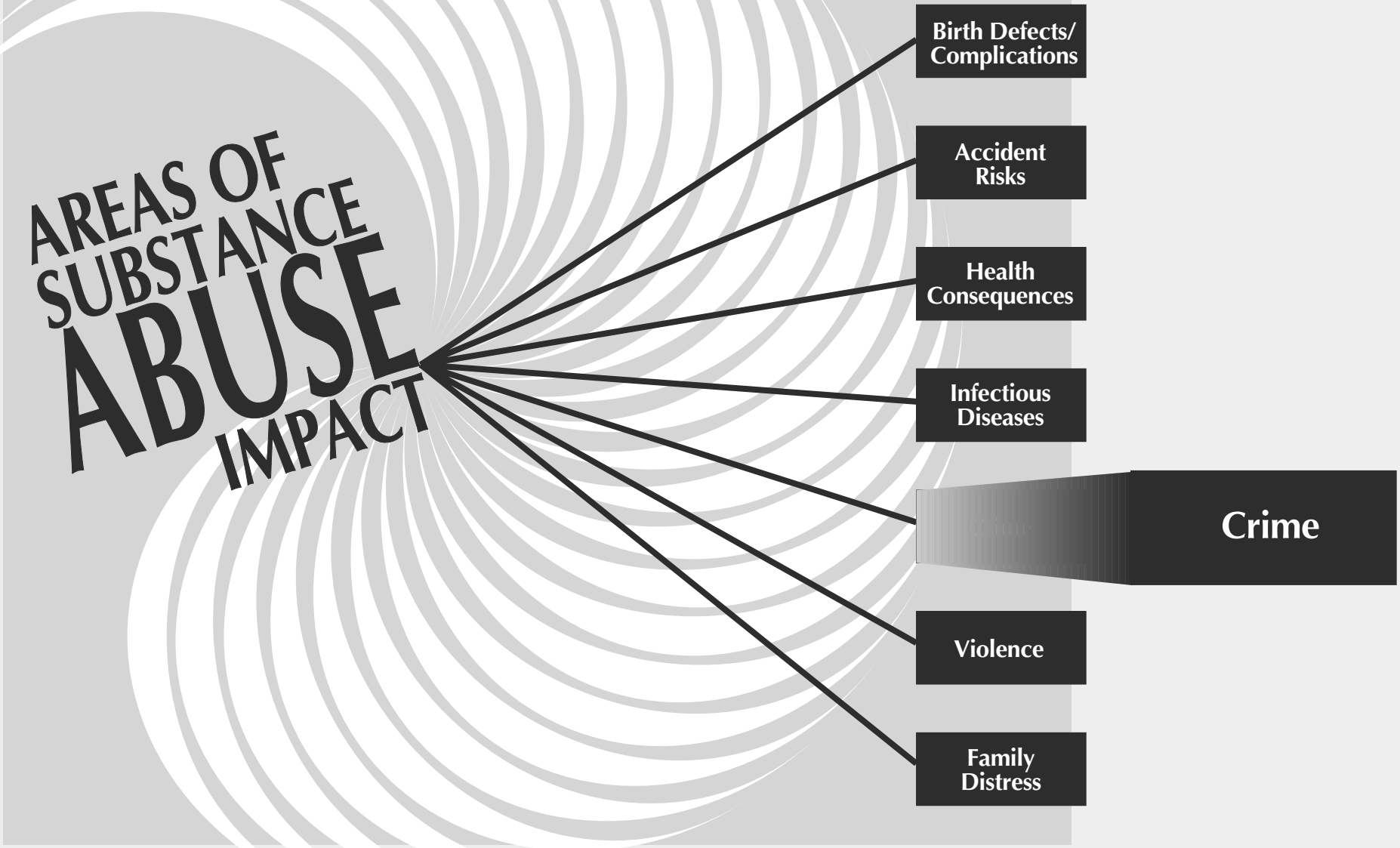


Source: National data from the Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Sexually Transmitted Disease Surveillance (2000). State data from the Washington State Department of Health, Annual Communicable Disease Report, 2000.

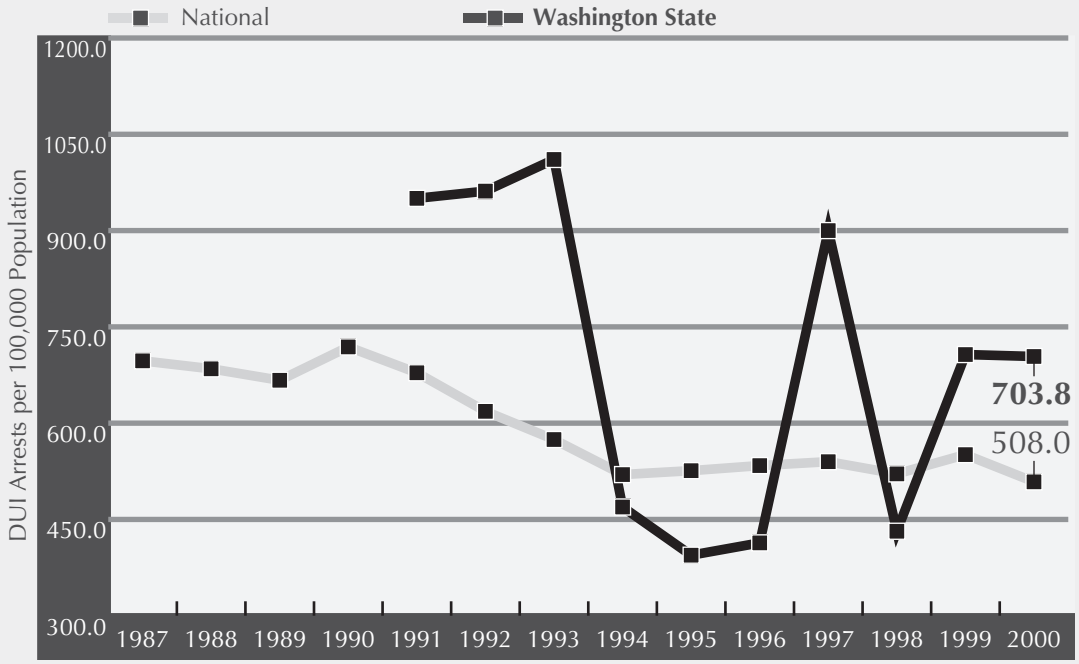
This graph indicates that the incidence of gonorrhea in both Washington State and the nation has declined significantly over the past 15 years. However, there has been a recent resurgence in cases in Washington State, from 1,955 cases in 1997 to 2,419 cases in 2000, a 21.4% increase. Gonorrhea infections are a major cause of pelvic inflammatory disease, tubal infertility, ecotopic pregnancy, and chronic pain. Gonorrhea rates serve as an indicator for other sexually transmitted diseases (STDs). Many studies document the association of substance use with STDs.[1]

[1] Beltrami, J., Wright-DeAquero, L., Fullilove., M., St. Louis, M., & Edlin, B. (1997). Substance abuse and the spread of sexually transmitted diseases. Paper commissioned for the Institute of Medicine, Committee on Prevention and Control of STDs.

The Problem: Substance Abuse Prevalence & Trends



Washington State Drunk Driving Laws Have Become Increasingly Tough in the Past Decade.

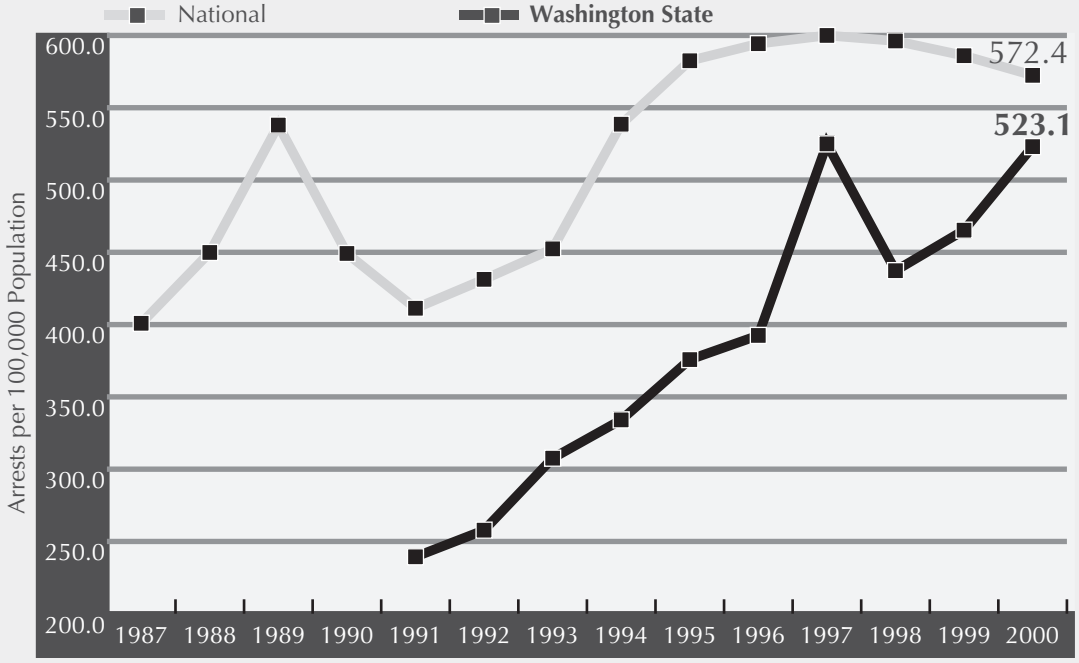


Source: National and state data from the U.S. Department of Justice, Federal Bureau of Investigation, "Crime in the United States" annual reports.

Data for driving under the influence (DUI) arrests may reflect a jurisdiction's laws, enforcement policy, financial resources, and officer discretion in addition to the actual level of alcohol- or drug-related driving incidents. Enactment of new DUI laws in Washington State in 1998 – including lowering the blood alcohol concentration for proof of intoxication from .10 to .08, and zero tolerance for drivers under age 21 – are likely to change the pattern of arrests in the future. Because both laws and enforcement are not consistent across states, national and state data may not be comparable.

Because the FBI did not begin reporting of state rates for DUI arrests until 1991, the Washington State data line begins there.

Washington State Has a Lower Arrest Rate for Drug Abuse Violations Than the Nation.

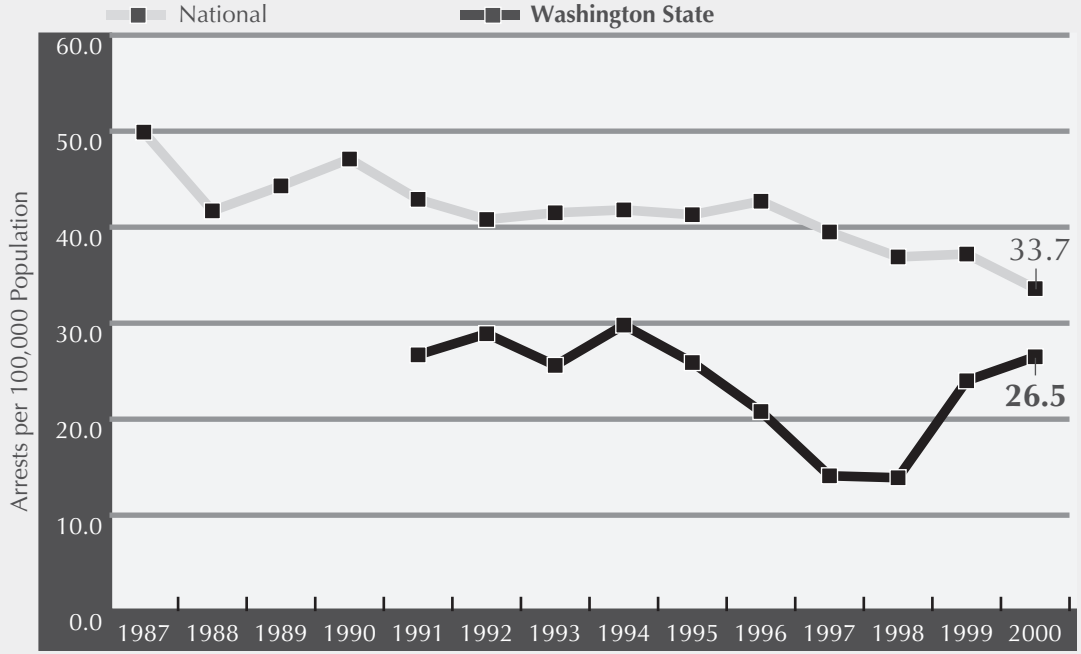


Source: National and state data from the U.S. Department of Justice, Federal Bureau of Investigation, "Crimes in the United States" annual reports.

This graph indicates that although fewer drug-related arrests per capita occur in Washington State than the nation, the rate is increasing. Arrests made for drug abuse violations provide a direct measure of illegal activity related to substance abuse. A drug abuse violation is any transgression of state or local laws that results from the unlawful possession, sale, use, growing, or manufacture of narcotic drugs. Arrest data may reflect a jurisdiction's financial resources, enforcement policy, and officer discretion as well as the actual level of drug-related criminal activity.

Because the FBI did not begin reporting of state rates for drug abuse violations until 1991, the Washington State data line begins there.

Arrest Rates in Washington State for Prostitution are Well Below the Nation's.

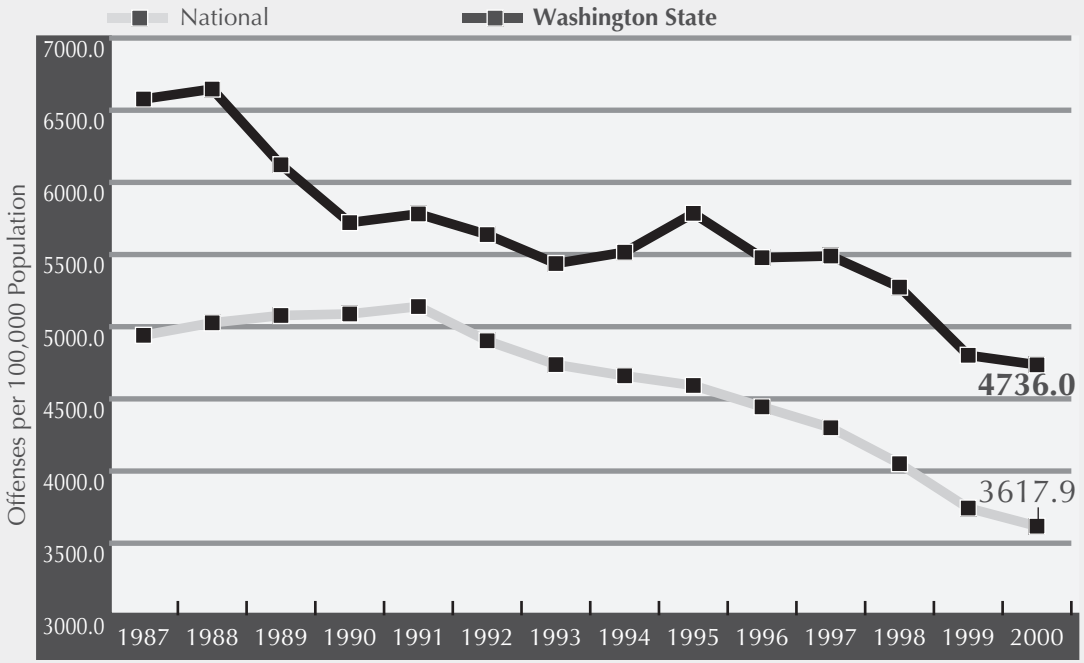


Source: National data from the U.S Department of Justice, Federal Bureau of Investigation, "Crime in the United States" annual reports. State data from Washington Association of Sheriffs and Police Chiefs, "Crime in Washington State" annual reports.

This graph indicates that arrest rates for prostitution in Washington State are significantly lower than that of the nation. It should be noted that arrest rates may be influenced by a jurisdiction's financial resources, enforcement policy, and officer discretion as well as the actual level of criminal activity. The Arrestee Drug Abuse Monitoring Program reports that 78.3% of those arrested for prostitution in Seattle in 1999 tested positive for illegal drugs, mostly for cocaine.[1]

[1] Office of Justice Programs. (2000). Arrestee drug abuse monitoring program 1999 annual report, p. 80. Washington, DC: U.S. Department of Justice, National Institute of Justice.

Washington State Has a Higher Property Crime Index than the Nation.



Source: National data from the Federal Bureau of Investigation, Uniform Crime Report. State data from Washington Association of Sheriffs and Police Chiefs, Crime in Washington State Annual Reports.

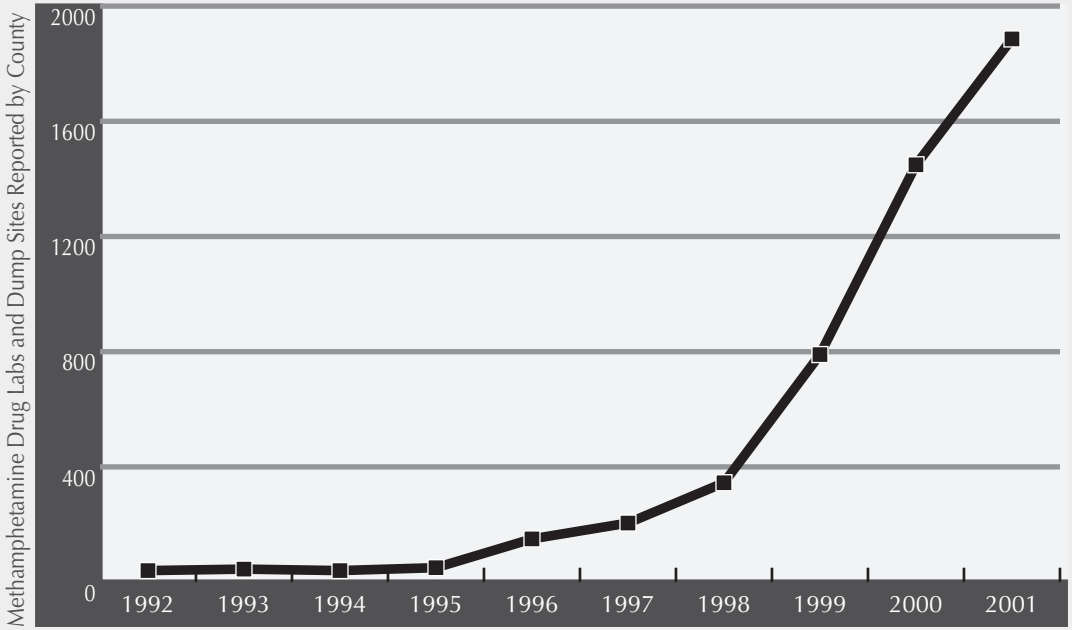
This graph indicates that the Washington State property crime index is higher than the nation's, but has dropped more than 28% since 1988. The property crime index includes burglary, larceny-theft, motor vehicle theft, and arson. Distinct from arrest data, this index counts one offense for each victim who reports a property crime to the police, regardless of the number of offenders involved.

The Arrestee Drug Abuse Monitoring Program found that in 2000, 73.4% of males arrested for property offenses in King County and 71.5% of males arrested for property offenses in Spokane County tested positive for illegal drugs.

[1] Office of Justice Programs. (2001). Arrestee drug abuse monitoring program 2000 annualized site reports, 139-146. Washington, DC: U.S. Department of Justice, National Institute of Justice.

The Number of Reported Methamphetamine Laboratories in Washington State Has Risen More than 45-Fold Since 1992.

Number of Reported Meth Labs and Dump Sites

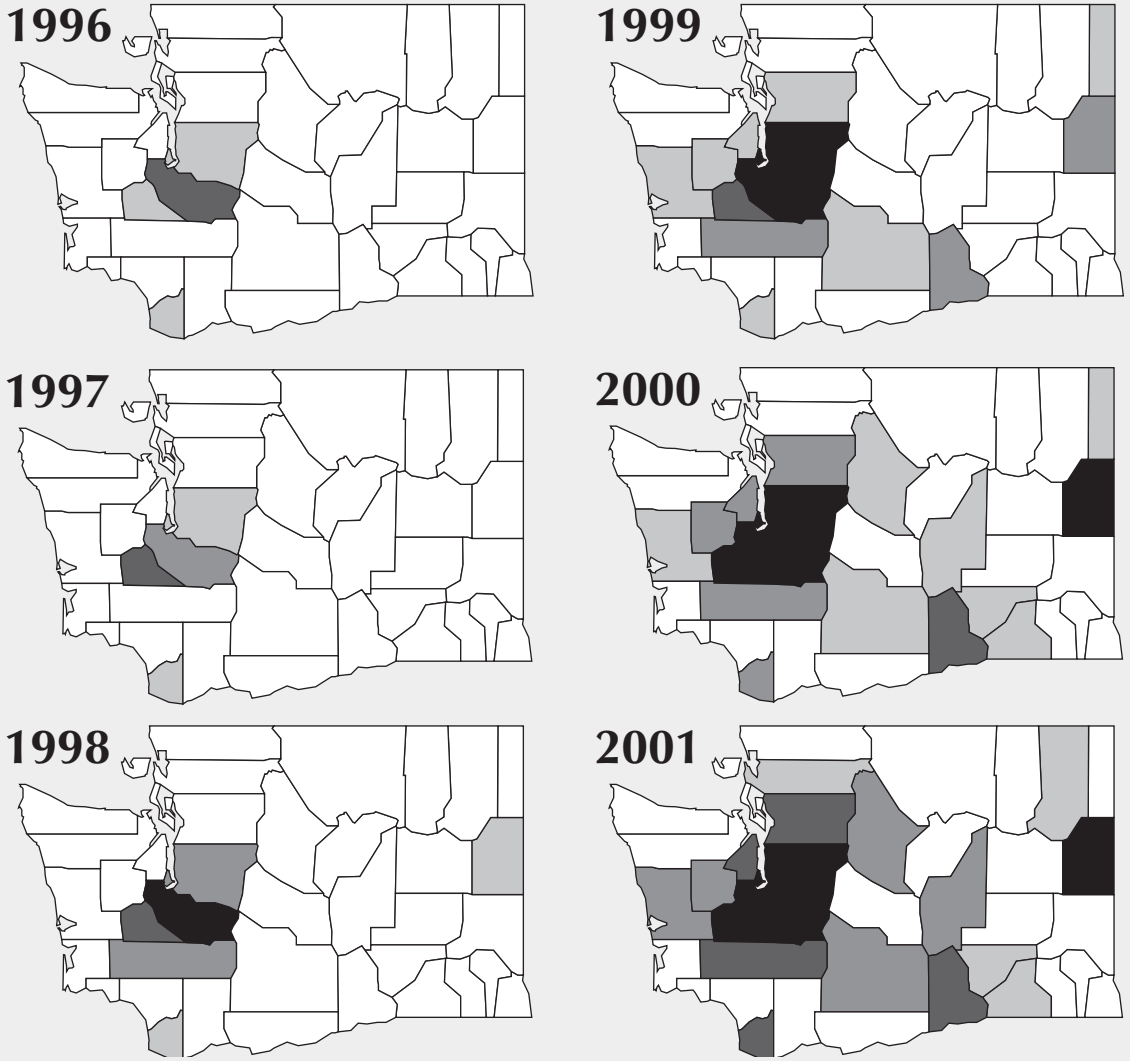


Source: Department of Ecology

This graph indicates the dramatic rise in the number of illegal methamphetamine (meth) laboratories and dump sites reported to the Department of Ecology since 1992. The number of reports increased 23% from 2000 to 2001, from 1,449 to 1,886. The largest number of these reports in 2000 came from Pierce (585), King (271), Spokane (248), and Thurston Counties. Counties in Eastern Washington are experiencing the largest increases, with the number of cases in Spokane County up 81%.

This data is consistent with other data indicating huge increases in the number of meth-related arrests, experimentation with meth by adolescents, and treatment admissions for methamphetamine addiction. However, it should be noted that the number of reported laboratories and dump sites peaked in February 2001 (202), and has dropped some 42% since then to 117 in December 2001.

Distribution of Methamphetamine Drug Laboratories and Dump Sites Reported by County



Source: Department of Ecology

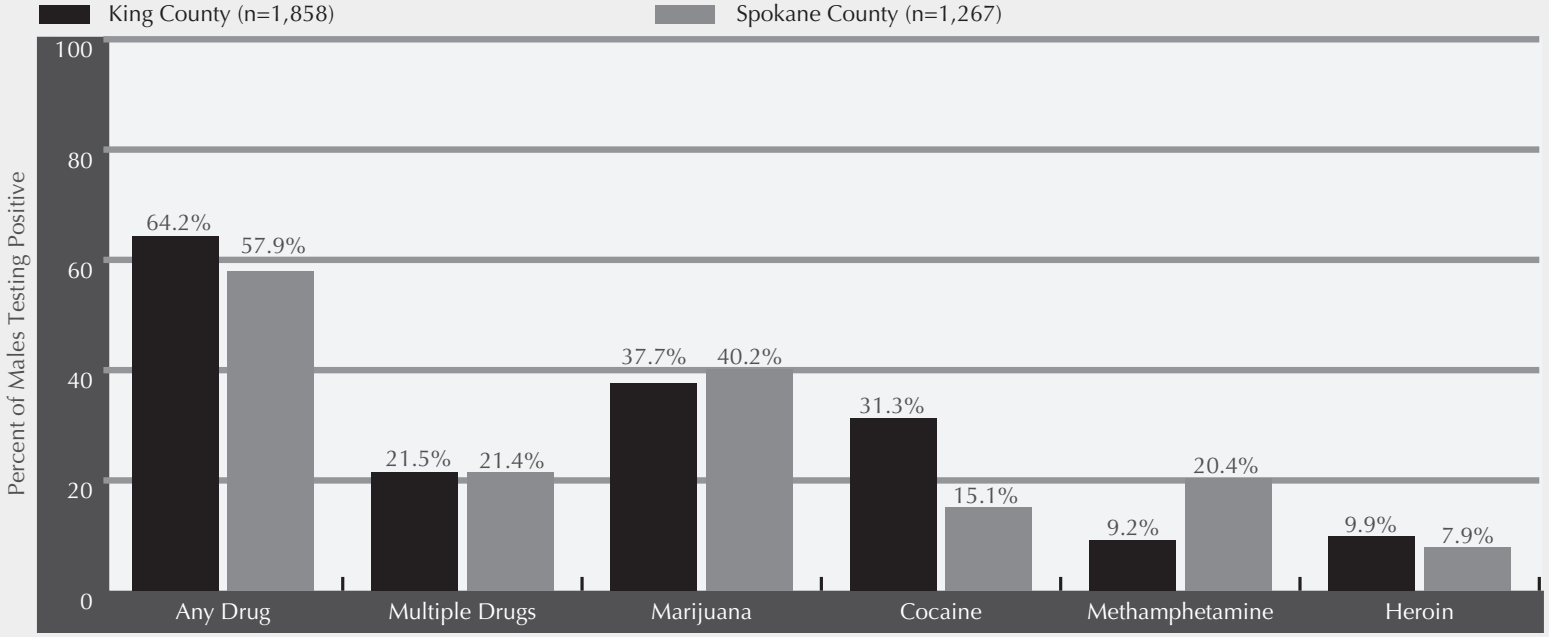
These maps indicate widespread increase in reports of methamphetamine drug labs and dump sites by county. In 1991, only two counties - Pierce and King - had as many as ten reports. There have been huge increases in reports since then: in Pierce, from 18 to 543; King, from ten to 231; Thurston from 4 to 139; Spokane, from zero to 137; and Benton from zero to 52. As can be seen from the maps, the epidemic is spreading rapidly to virtually all portions of the state.

Number of Reported Methamphetamine Laboratories and Dump Sites in Washington State

County	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Adams	-	-	-	-	-	1	-	1	-	3
Asotin	-	-	-	-	-	-	-	1	1	5
Benton	-	-	-	1	3	4	7	38	52	85
Chelan	-	1	-	1	1	-	-	2	14	34
Clallam	-	-	1	1	1	3	3	-	1	3
Clark	4	1	3	3	12	20	12	16	34	57
Columbia	-	-	-	-	-	-	-	1	3	2
Cowlitz	3	1	-	1	3	9	2	8	7	9
Douglas	-	-	-	-	-	-	1	1	6	5
Ferry	-	-	-	-	-	-	-	-	7	4
Franklin	-	-	-	-	-	-	1	8	10	15
Garfield	-	-	-	-	-	-	-	2	-	-
Grant	2	-	-	1	-	-	-	2	19	27
Grays Harbor	-	2	2	1	3	5	5	16	24	41
Island	-	-	-	1	-	1	2	5	1	5
Jefferson	-	-	-	-	-	1	1	2	7	6
King	2	7	7	10	23	17	48	107	231	271
Kitsap	2	1	-	-	3	-	1	21	45	54
Kittitas	-	1	-	1	-	-	1	3	-	5
Klickitat	1	-	-	1	1	1	3	-	6	4
Lewis	1	2	3	4	7	9	31	33	43	61
Lincoln	-	-	-	-	-	-	-	-	-	5
Mason	-	2	-	-	4	4	10	21	32	30
Okanogan	1	-	-	-	-	2	3	2	2	3
Pacific	-	-	-	1	-	4	1	6	2	3
Pend Oreille	-	1	-	-	-	2	6	10	12	5
Pierce	18	12	17	17	53	42	129	318	543	585
San Juan	-	-	-	-	-	-	-	-	-	1
Skagit	-	1	-	1	-	-	4	2	5	11
Skamania	-	-	-	-	-	-	-	2	1	2
Snohomish	-	2	-	-	7	6	5	13	34	69
Spokane	-	-	1	2	1	7	11	36	137	248
Stevens	-	-	-	-	1	1	-	5	4	15
Thurston	5	4	2	6	25	63	58	86	139	151
Wahkiakum	-	-	-	-	-	-	-	1	-	2
Walla Walla	-	-	-	-	-	-	2	8	12	16
Whatcom	-	1	-	-	-	-	-	-	-	5
Whitman	-	-	-	-	-	-	-	-	1	3
Yakima	-	2	-	1	5	1	2	12	14	36
TOTAL	**40**	**42**	**36**	**54**	**153**	**203**	**349**	**789**	**1,449**	**1,886**

Source: Department of Ecology.

Over Half of Males Arrested and Booked Into Jails in King and Spokane Counties in 2000 Tested Positive for Drugs.



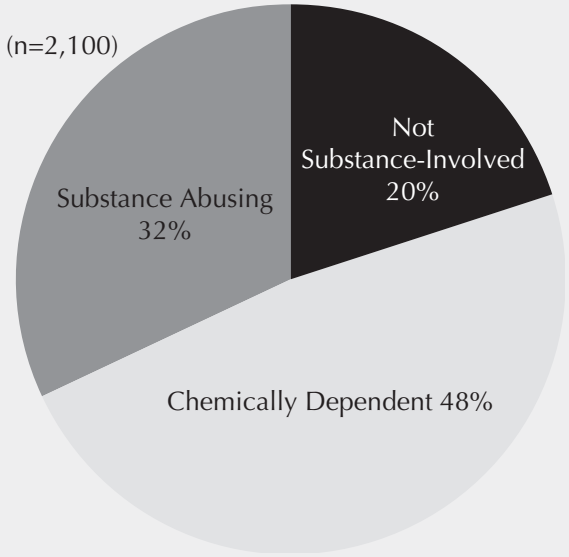
Source: Office of Justice Programs. (2001). 2000 Annualized Site Reports: Arrestee Drug Abuse Monitoring Program. Washington, DC: U.S. Department of Justice, National Institute of Justice.

Through the Arrestee Drug Abuse Monitoring (ADAM) Program, individuals arrested and booked into jails in King and Spokane Counties are periodically tested via urine sampling for drug use at time of booking. Some 64.2% of King County arrestees, and 57.9% of Spokane County arrestees tested positive for drugs in 2000. In addition, more than 70% of those booked for property offenses tested positive.

There are regional differences. The percentage of King County arrestees testing positive for cocaine is twice the percentage in Spokane County. In contrast, the percentage of arrestees in Spokane County testing positive for methamphetamine is double that of those in King County.[1]

[1] Office of Justice Programs. (2001). 2000 annualized site reports: Arrestee Drug Abuse Monitoring (ADAM) Program, 139-146. Washington DC: U.S. Department of Justice, National Institute of Justice.

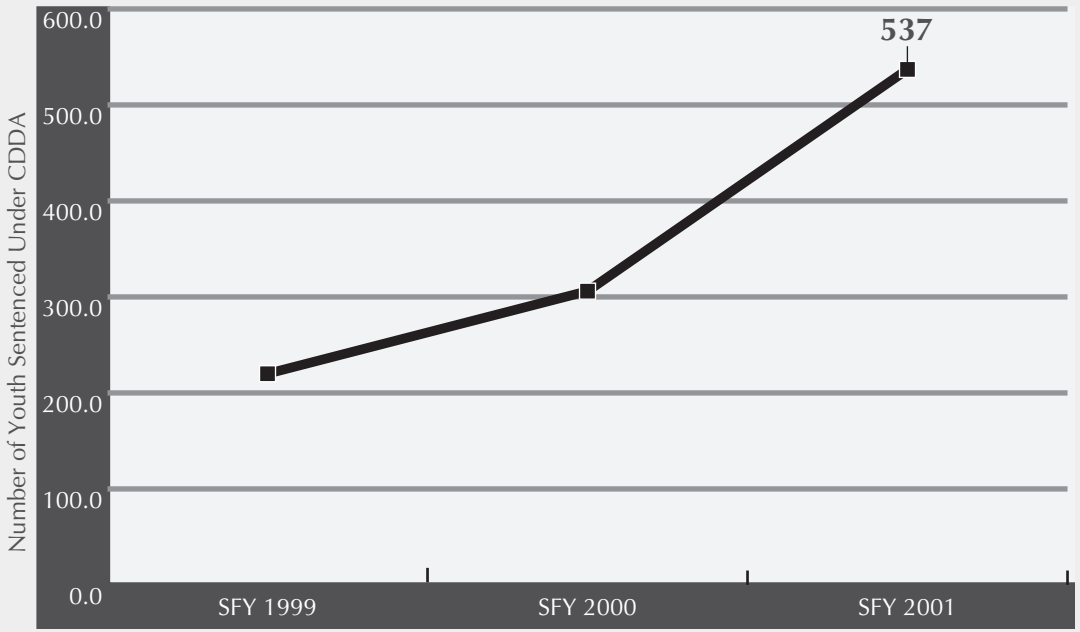
Approximately 80% of Youth Entering Juvenile Rehabilitation Administration Facilities Have Substance Abuse-Related Problems.



Source: Department of Social and Health Services, Juvenile Rehabilitation Administration, Client Tracking System, July 2001.

Four out of five youth sentenced through the juvenile justice system to Juvenile Rehabilitation Administration (JRA) institutions have substance abuse-related problems. JRA offers a continuum of chemical dependency treatment services within its facilities. All services are certified by the Division of Alcohol and Substance Abuse (DASA). Approximately 270 youth are served each month, receiving intensive outpatient, outpatient, day, and inpatient treatment.

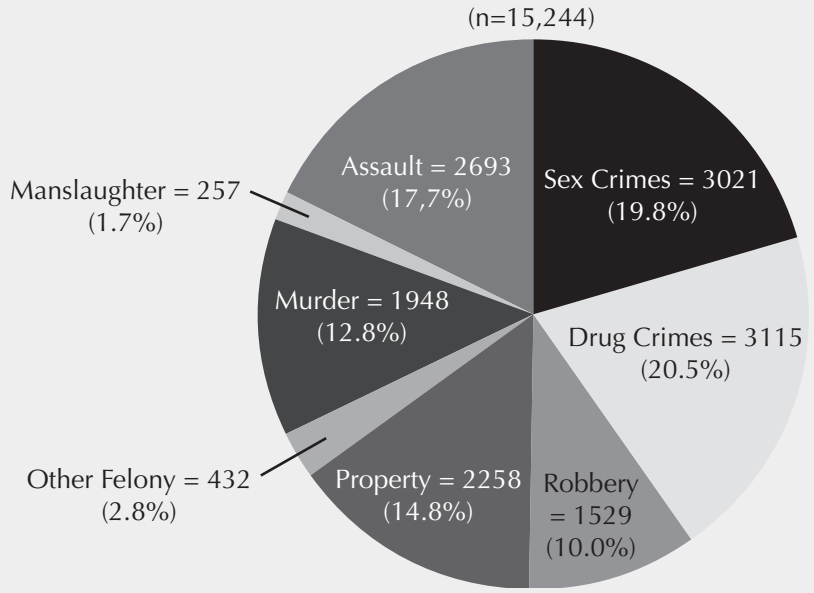
In State Fiscal Year 2001, 537 Youth Who Committed Offenses Received Treatment Under the Chemical Dependency Disposition Alternative.



Source: Department of Social and Health Services, Juvenile Rehabilitation Administration, Client Tracking System.

In 1998, the Legislature created the Chemical Dependency Disposition Alternative (CDDA). Under CDDA, juvenile courts are provided the option of sentencing chemical abusing and dependent youth to treatment rather than confinement. CDDA represents a collaboration between JRA, DASA, the Medical Assistance Administration, local juvenile courts, University of Washington, and county alcohol/drug coordinators. Annual reports are provided to the Legislature on the effectiveness of CDDA programs. An outcome evaluation currently underway will examine CDDA's effectiveness in decreasing recidivism, reducing substance abuse, and improving school performance.

More Inmates in Department of Corrections Custody are Convicted of Drug Offenses than Any Other Class of Crime.

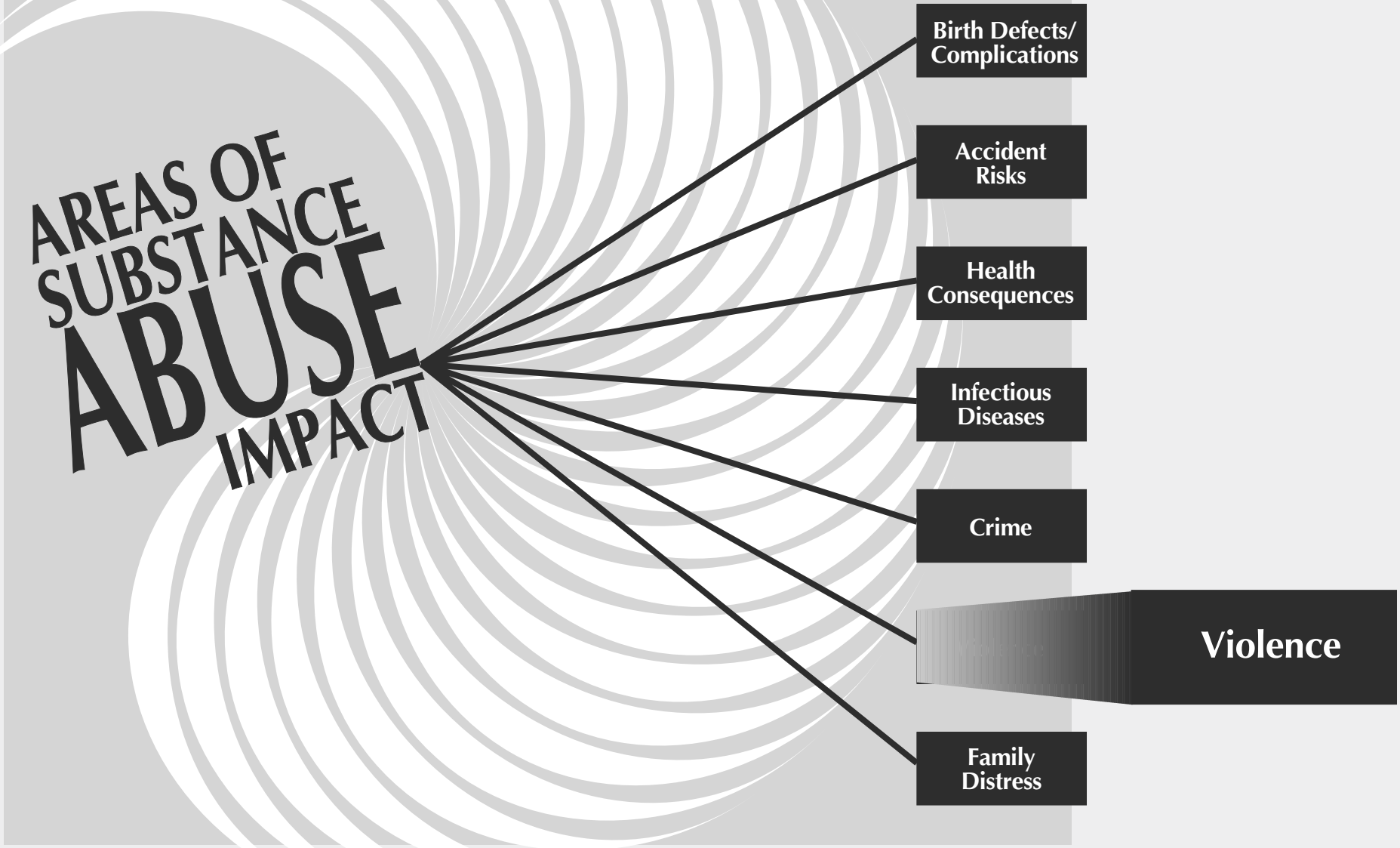


Source: Client Characteristics, Population Movement, and Custody: Report for Fiscal Year 2002 As of December 31, 2001. Washington State Department of Corrections, Planning and Research Section.

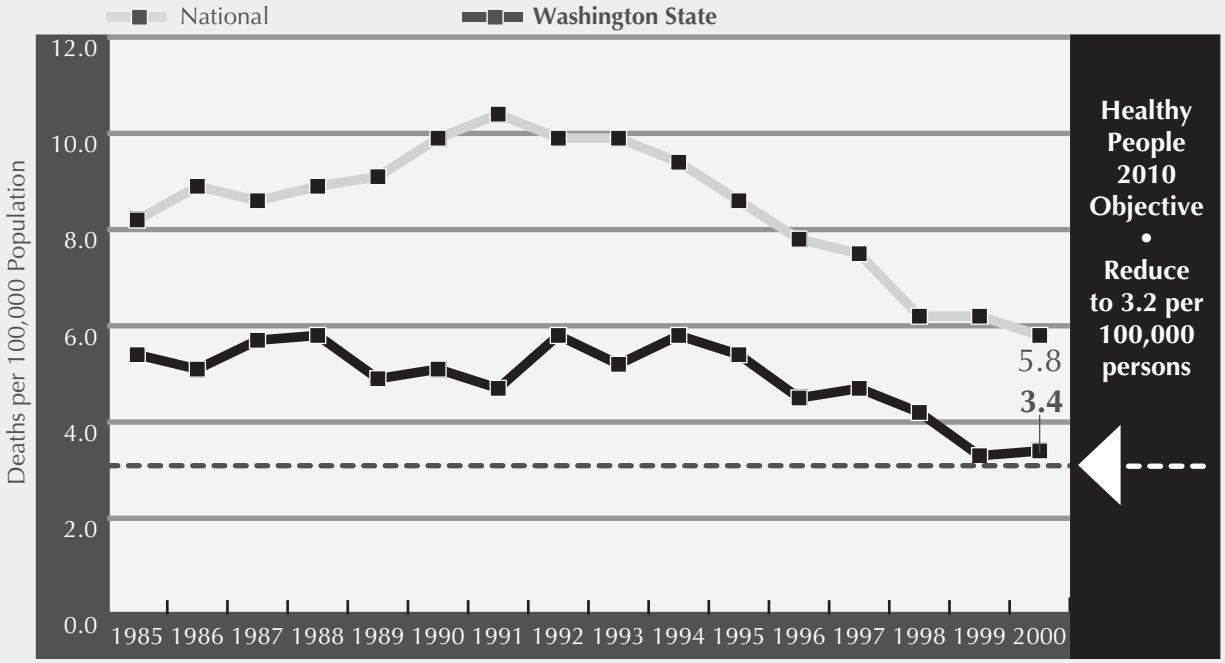
More than one in five inmates in the custody of the Department of Corrections – in prisons, pre-release facilities, and work release – were convicted of drug offenses, making drug crimes the largest category of offenses. Between 60-80% of inmates are estimated to be in need of treatment.[1] More than 60% of homicide deaths in 2000 were either drug-related or committed under the influence of alcohol.[2] In addition, the Arrestee Drug Abuse Monitoring Program found that more than half of males arrested for violent offenses in King and Spokane Counties tested positive for illegal drugs.[3]

[1] Department of Corrections, January 2002.
[2] Washington Uniform Crime Reporting System. (2000). Crime in Washington State, 2000 annual report, 13. Olympia, WA: Washington Association of Sheriffs and Police Chiefs and Washington State Criminal Justice Training Commission.
[3] Office of Justice Programs. (2001). Arrestee drug abuse monitoring program 2000 annualized site reports, pp. 139-146. Washington, DC: U.S. Department of Justice, National Institute of Justice.

The Problem: Substance Abuse Prevalence & Trends



Washington State Has a Lower Homicide Rate than the Nation.



Source: National data from the National Vital Statistics System, Centers for Disease Control and Prevention, National Center for Health Statistics; state data from Washington State Department of Health, Center for Health Statistics.

This graph indicates that Washington State's homicide rate has been lower than the national rate since 1985. The homicide rate in both Washington State and nationally has dropped significantly since 1995.

Homicide is the second leading cause of death in the United States for young peoples ages 15-24. The homicide rate among males ages 15-24 in the United States is ten times higher than in Canada, 15 times higher than in Australia, and 28 times higher than in France or Germany.[1]

The use, manufacture, and distribution of illegal drugs are strongly associated with homicide. The Washington Association of Sheriffs and Police Chiefs reports that 26 of the 47 felony homicide deaths in 2000 (55.3%) were drug-related. In addition, 13 of the 149 non-felony homicide deaths in 2000 (8.7%) occurred as a result of brawls under the influence of alcohol.[2]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 15-43. Washington, DC.
[2] Washington Uniform Crime Reporting System. (2000). Crime in Washington State, 2000 annual report, 13. Olympia, WA: Washington Association of Sheriffs and Police Chiefs and Washington State Criminal Justice Training Commission.

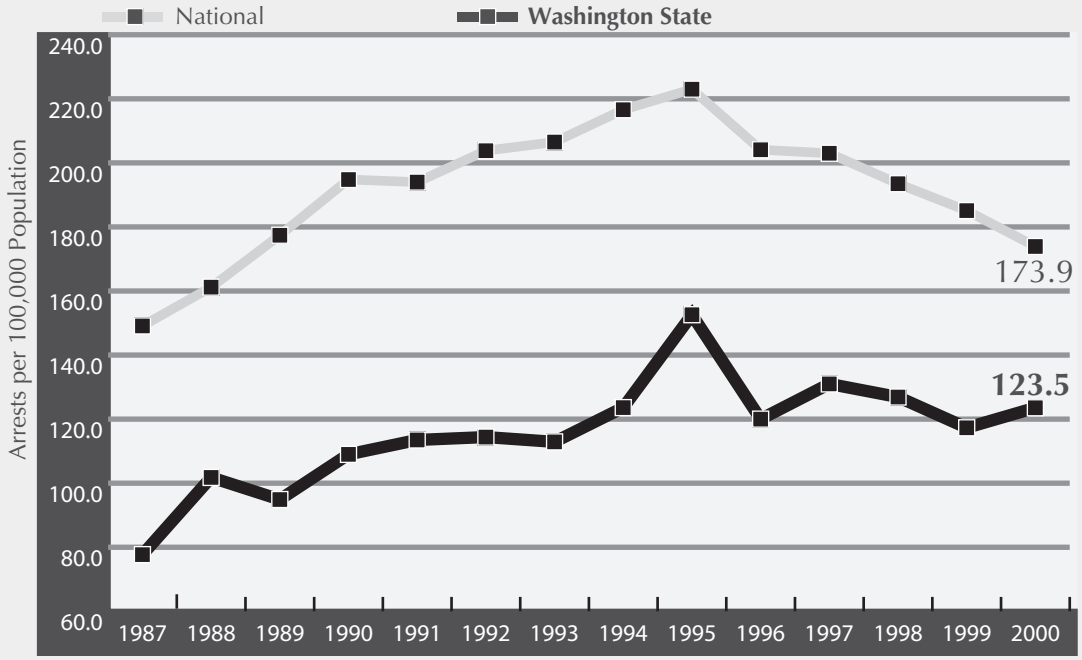
Washington State Has a Consistently Higher Suicide Rate than the Nation.

Source: National data from the National Vital Statistics System, Centers for Disease Control and Prevention, National Center for Health Statistics. State data from Washington State Department of Health, Center for Health Statistics.

This graph indicates that Washington State has a higher suicide rate than the nation, and is above the ***Healthy People 2010*** objective. Suicide is the second leading cause of death for young people ages 15-24 in Washington State. A recent study found that use of alcohol almost doubles the risk of suicide in the home, while use of illegal drugs is associated with a seven-fold increase in risk.[1]

[1] Rivara, F., Mueller, B, Somes, G, Mendoza, C., Rushforth, N., & Kellermann, A. (1997). Alcohol and illicit drug abuse and the risk of violent death in the home. Journal of the American Medical Association 278(7), 569=575.

The Aggravated Assault Arrest Rate in Washington State Remains Well Below the National Rate.



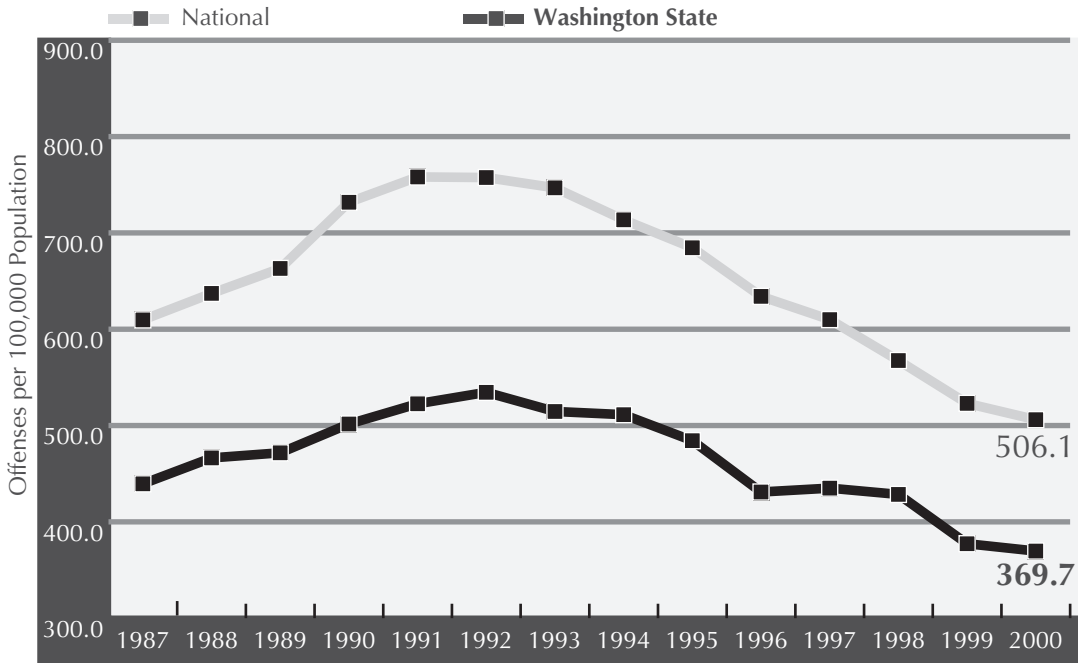
Source: National and state data from the U.S. Department of Justice, Federal Bureau of Investigation, "Crime in the United States" annual reports.

The federal Uniform Crime Reporting Program defines an aggravated assault as the unlawful attack by one person on another for the purpose of inflicting severe or aggravated bodily injury. An assault of this type is usually accompanied by the use of a weapon or by means likely to produce death or severe harm.[1]

This graph indicates that Washington State has a consistently lower rate of aggravated assault arrests than the nation. Arrest data may reflect a jurisdiction's financial resources, enforcement policy, and officer discretion as well as the actual level of criminal activity.

[1] Federal Bureau of Investigation. (1984). Uniform crime reporting handbook, 16. Washington, DC: U.S. Department of Justice.

Washington State Consistently Has a Lower Rate of Violent Crime than the Nation.



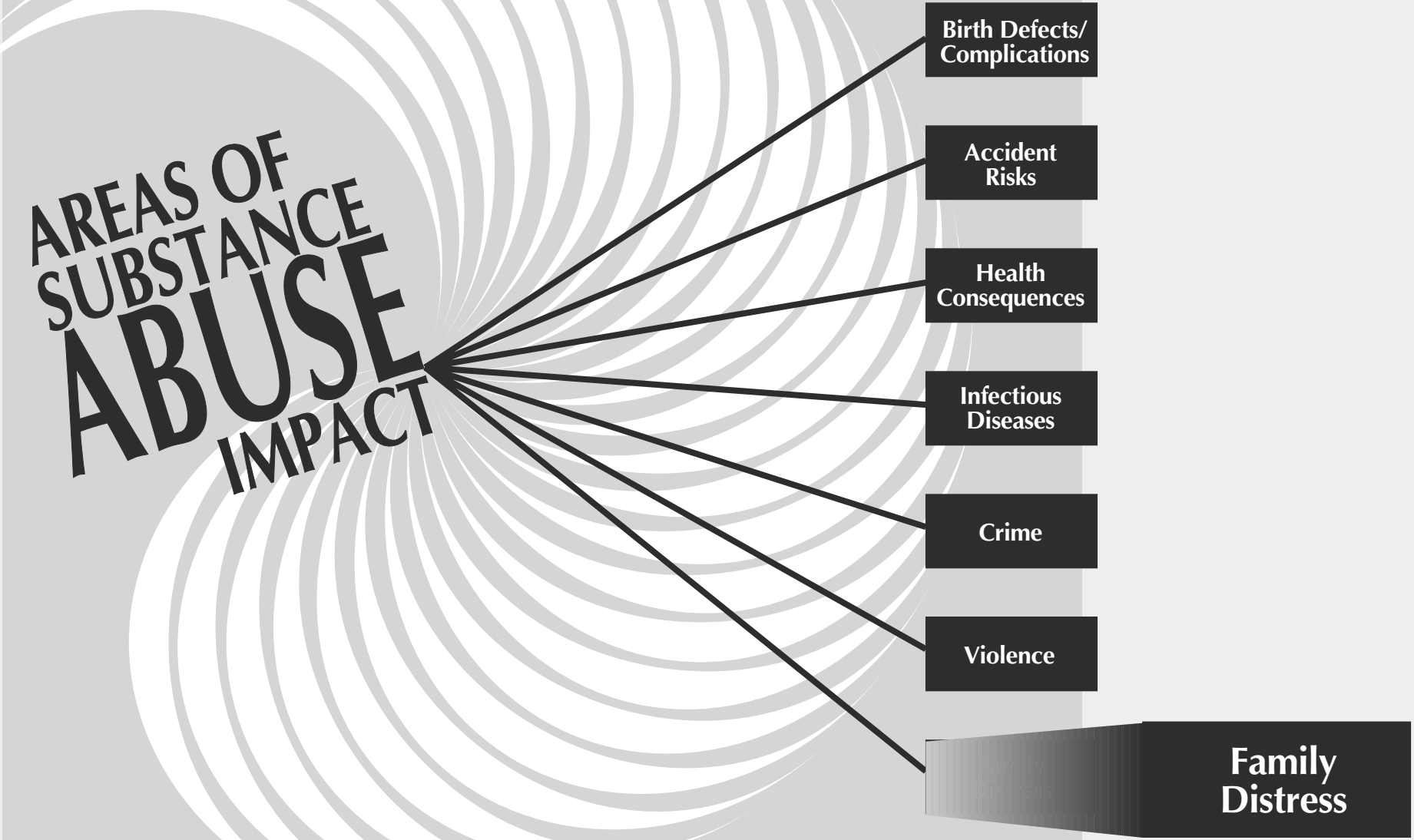
Source: National and state data from the U.S. Department of Justice, Federal Bureau of Investigation, "Crime in the United States" annual reports.

The most serious felony crimes against persons comprise the violent crime index. These offenses include murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. All violent crimes involve force or the threat of force. This index is based upon offenses that become known to police, regardless of whether or not an arrest occurs.

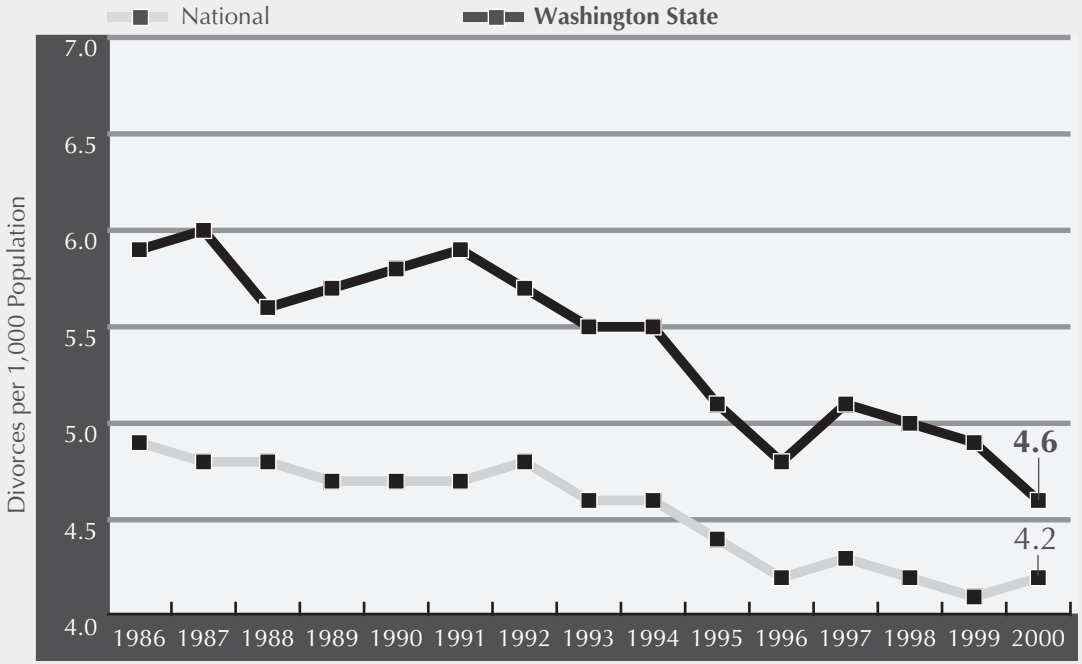
This graph shows that Washington has consistently experienced a lower incidence of violent crime than the nation for more than a decade. Violent crime rates both in Washington and the nation have been falling for well over a decade. The Arrestee Drug Abuse Monitoring Program found that in 2000, 56.9% of males arrested for violent offenses in King County and 50.0% of males arrested for violent offenses in Spokane County tested positive for illegal drugs.[1]

[1] Office of Justice Programs. (2001). Arrestee drug abuse monitoring program 2000 annualized site reports, 139-146. Washington, DC: U.S. Department of Justice, National Institute of Justice.

The Problem: Substance Abuse Prevalence & Trends



Washington State Has a Higher Divorce Rate than the Nation.



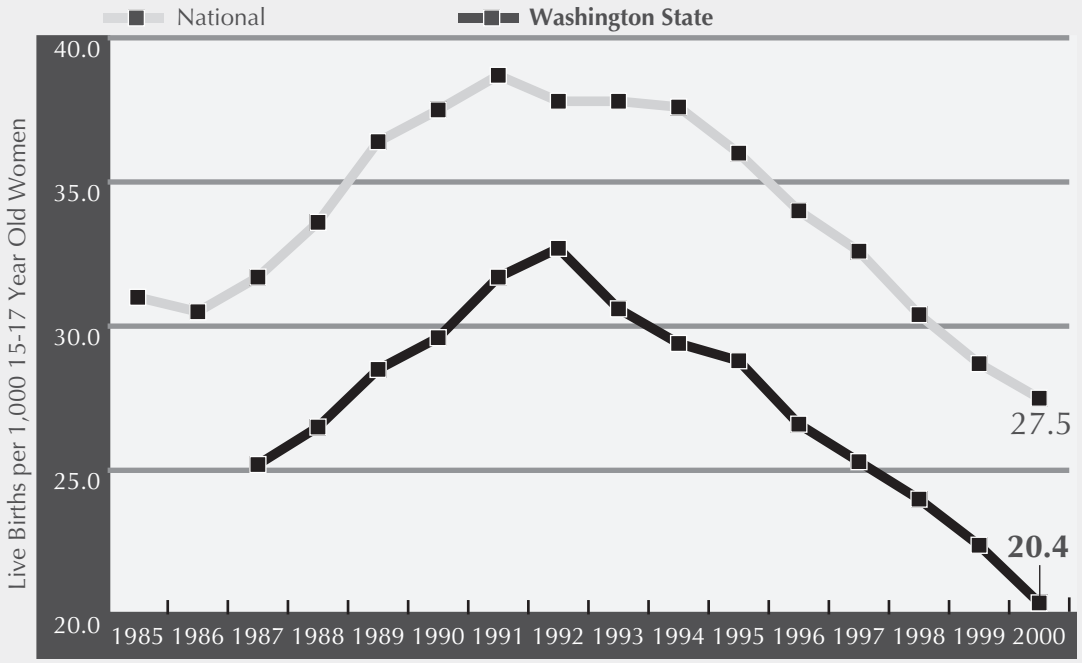
Source: National data from National Center for Health Statistics. State data from Washington State Department of Health, Center for Health Statistics.

This graph indicates that couples in Washington State experience more divorces (including annulments) than couples nationally. In 1999, 51.9% of the 28,378 divorces in Washington State involved families with children.

Studies indicate children from homes broken by marital discord are at higher risk of drug use.[1]

[1] Kabel, J., Kohlenberg, E., Flewelling, R. & Shaklee, M. (1997). Profile on risk and protection for substance abuse planning in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, and Research and Data Analysis.

The Birth Rate Among Teens Ages 15-17 in Washington State is Now At Its Lowest Point in 15 Years.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Washington State Department of Health, Center for Health Statistics.

This graph indicates the number of births per thousand among teens ages 15-17 is lower in Washington State than the nation, and continues to fall. It is now at its lowest level in 15 years.

Teen pregnancy and births pose substantial health and other risks to both mothers and children. Maternal age is a significant risk factor for infant mortality.[1] Of 781,900 pregnancies to women ages 15-19 in 1994, 78% were unintended.[2] In 1994, the teen pregnancy rate in the United States was twice as high as in England, Wales, France, and Canada, and nine times as high as in the Netherlands and Japan.[3]

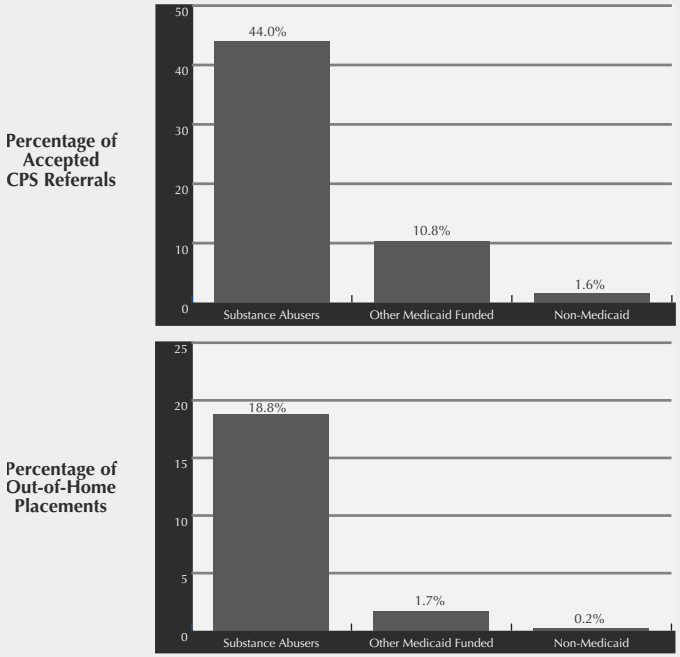
In a survey of women in Washington State who were 18 years of age or younger at the time of their first pregnancy, almost one-quarter reported having used alcohol or another drug when they first became pregnant, and 36% reported that their partner used alcohol or drugs at that time.[4]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 16-3. Washington, DC.
[2] Henshaw, S.K. (1998). Unintended pregnancy in the United States. Family Planning Perspectives 30(1):24-29, 46.
[3] Title X and the U.S. Family Planning Effort. (1997). New York, NY: Alan Guttmacher Institute.
[4] Boyer, D., & Fine, D. (1992). Sexual abuse as a factor in adolescent pregnancy and child maltreatment. Family Planning Perspectives 24(1), 4-12.

Infants Born to Low-Income Substance-Abusing Women Account for a Disproportionate Share of Child Protective Service (CPS) Referrals and Out-of-Home Placements.

44% of Infants Born to Substance-Abusing Women Were Reported at "High Risk" of Imminent Harm.

18% of Infants Born to Substance-Abusing Women Were Placed Out of Home.

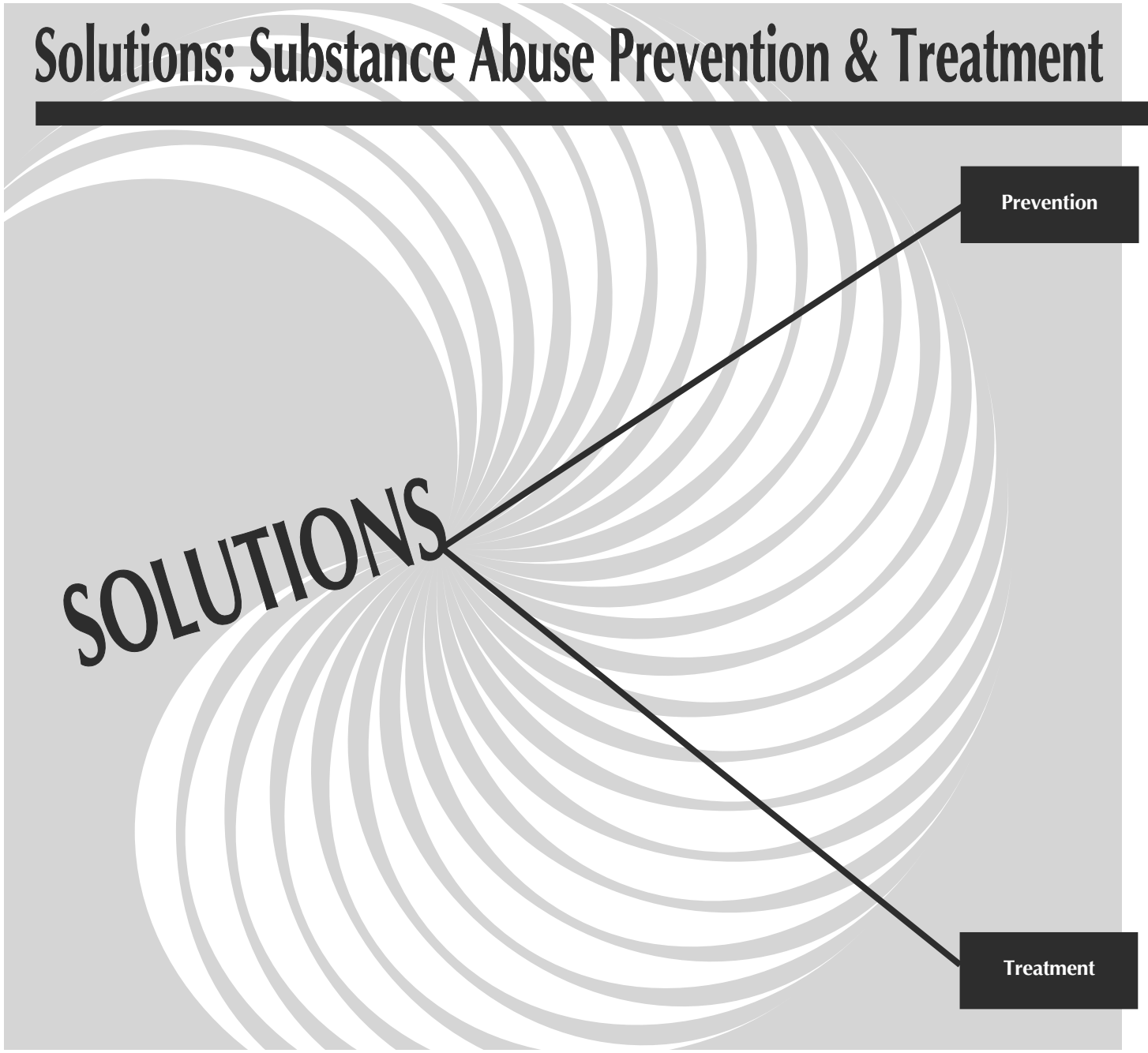


Source: Cawthon, L., & Schrager (1995). First Steps Database: Substance Abuse, Treatment, and Birth Outcomes for Pregnant Women in Washington State. Olympia, WA: Washington State Department of Social and Health Service, Office of Research and Data Analysis.

Researchers have consistently found an association between alcohol and other drug abuse and virtually all forms of interpersonal violence, including child abuse and neglect. The 1997 Child Maltreatment report from states to the National Child Abuse and Neglect Data System found approximately 984,000 victims of child maltreatment. Neglect accounted for 55.9% of these reports, followed by 24.6% for physical abuse, 12.5% sexual abuse, and 6.1% emotional abuse. It should be noted that 58.8% of the substantiated or indicated reports of maltreatment were from professional sources: legal, medical, social service, or educational professionals.[1]

[1] U.S. Department of Health and Human Services. (2000). Healthy people 2010 (Conference Edition), 15-44. Washington, DC.

Solutions: Substance Abuse Prevention & Treatment



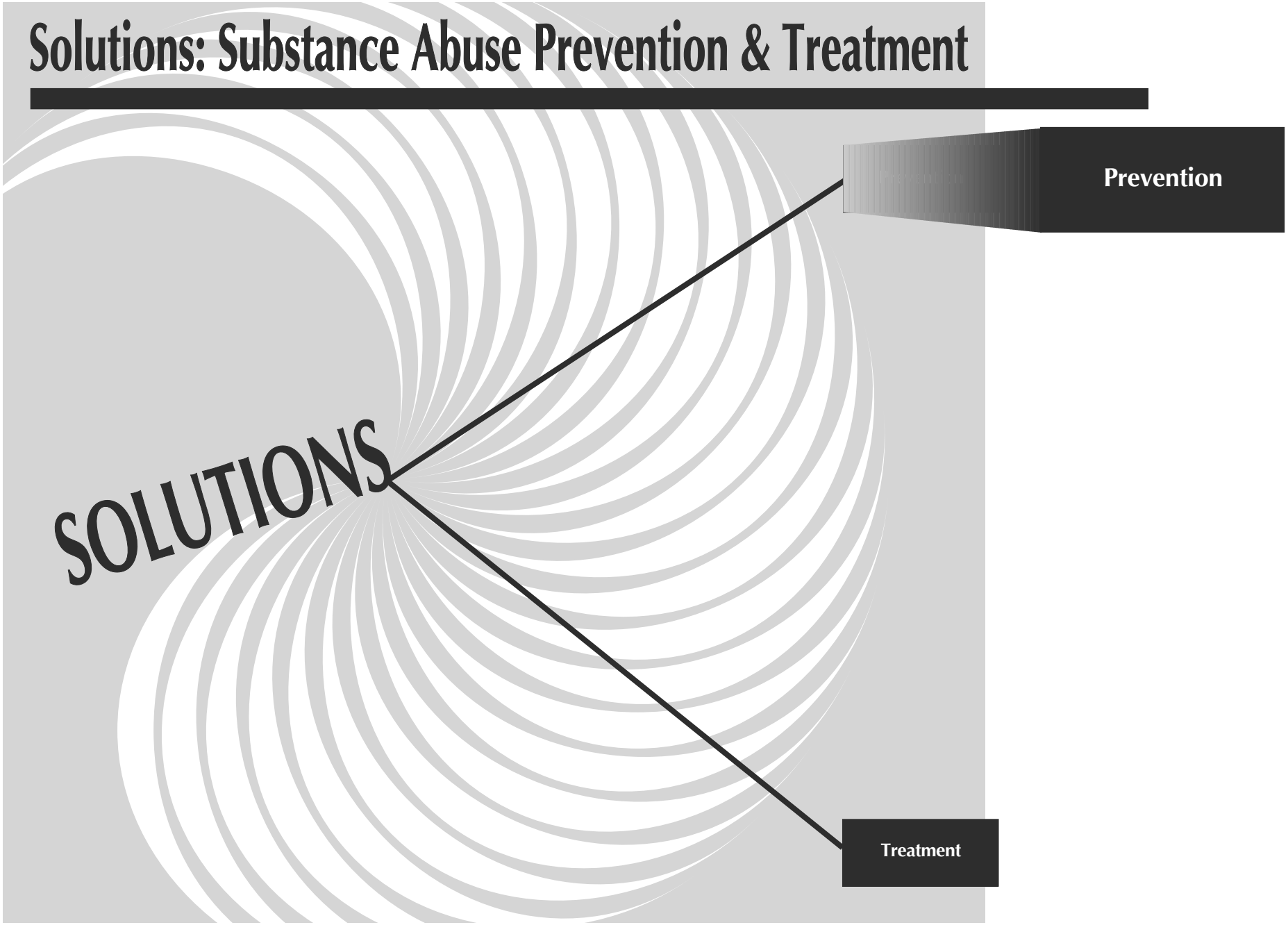
Introduction

State Law RCW 70.96A identifies the Division of Alcohol and Substance Abuse (DASA) as the "single state" agency for planning and delivery of substance abuse treatment and prevention services. All public substance abuse services funded by state or federal funds are either managed by DASA or operate in coordination with DASA (for example, services provided by the Department of Health, the Department of Licensing, the Department of Corrections and the Office of the Superintendent of Public Instruction).

DASA does not provide direct prevention or treatment services, but rather, provides these services through contracts with county governments, Indian tribes, and non-profit service providers. The largest portion of available federal and state funds are contracted through county and tribal governments. Each biennium, DASA develops a plan for program development and prevention and treatment service strategies.

County governments and tribes are awarded prevention and treatment funds on the basis of a formula established by DASA in coordination with these governmental units. Counties and tribes are expected to conduct a needs assessment for prevention and treatment needs, based on the available funding and submit a plan to DASA. Contracts for community-based prevention and treatment services are written to include work statements specifying the activities which will be provided under the contracts.

Solutions: Substance Abuse Prevention & Treatment



Prevention

The Division of Alcohol and Substance Abuse's (DASA) Prevention Program is aimed at preventing alcohol, tobacco, and other drug use and abuse, reducing their negative consequences and, minimizing future needs for chemical dependency treatment.

DASA's prevention program covers all segments of the population at potential risk for drug and alcohol use and abuse. However, the primary focus is on children who have not yet begun use or are still only experimenting. Research indicates that youth who initiate alcohol and/or other drug use before the age of 15 are twice as likely to experience alcohol or drug problems than those who wait until after the age of 19.[1] The U.S. Surgeon General's 1994 Report, "Preventing Tobacco Use Among Young People," found that if adolescents are kept tobacco-free, they are extremely unlikely to take up tobacco use later in life.[2]

DASA has two main prevention goals: 1) delay onset of use; and 2) reduce alcohol, tobacco, and other drug misuse. DASA has also adopted performance measures for the 1999-2001 Biennium: to increase the number of children in each of three grades – 6th, 8th, and 10th – who have not used alcohol, tobacco, or marijuana in the past 30 days.

The Division's Philosophy

DASA has adopted a "risk and protective factor" approach as the conerstone of its efforts to prevent alcohol and other drug abuse. Risk factors are personal, family or community characteristics that increase the likelihood an individual will use alcohol or other drugs. Protective factors are similar characteristics that help insulate individuals from substance-abusing behaviors.

Seventeen risk factors have been identified for substance use/abuse, in four major categories:

1. Community:

- Availability of alcohol, tobacco, and other drugs
- Community laws and norms favorable to substance use
- Transitions and mobility
- Low neighborhood attachment and disorganization
- Extreme economic deprivation

2. Family:

- Family history of substance abuse
- Family management problems
- Family conflict
- Favorable parental attitudes and involvement with substance abuse

3. School:

- Early and persistent antisocial behavior
- Academic failure beginning in elementary school
- Lack of commitment to school

4. Individual/Peers:

- Rebelliousness
- Friends who use
- Favorable attitudes towards substance use
- Early initiation of substance use
- Constitutional factors[3]

Protective factors include individual protective characteristics, bonding to family, school, community and/or peers, and healthy beliefs and clear standards for behavior.

DASA contracts with the Department of Social and Health Service' Research and Data Analysis to compile risk and protection profiles for each of the 39 counties. These profiles provide substantial support to counties in program planning resource allocation, and the development of outcome measures.

[1] Developmental Research Programs (1996). Communities that care planning kit. Seattle, WA: Developmental Research Programs.
[2] U.S. Surgeon General (1994). Preventing tobacco use among young people: a report of the Surgeon General. Washington, DC: U. S. Department of Health and Human Services.
[3] Hawkins, J., Catalano, R. & Miller, J. (1992). Risk and protectivew factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse preventions. Psychological Bulletin. 112 (1), pp. 64-105.

Evidence-Based Principles for Substance Abuse Prevention

The National Drug Control Strategy's Performance Measures of Effectiveness require the White House Office of National Drug Control Policy (ONDCP) to "develop and implement a set of research-based principles upon which prevention programming can be based." Drawing upon literature reviews and guidance from the federal Departments of Education, Justice, and Health and Human Services, ONDCP has adopted 15 "Evidence Based Principles for Substance Abuse Prevention"[1]:

Address Appropriate Risk and Protective Factors for Substance Abuse in a Defined Population

1. Define a population.

2. Assess levels of risk, protection, and substance abuse for that population.

3. Focus on all levels of risk, with special attention to those exposed to high risk and low protection.

Use Approaches That Have Been Shown to Be Effective

4. Reduce the availability of illicit drugs, and of alcohol and tobacco for the under-aged.

5. Strengthen anti-drug-use attitudes and norms.

6. Strengthen life skills and drug refusal techniques.

7. Reduce risk and enhance protection in families.

8. Strengthen social bonding.

9. Ensure that interventions are appropriate for the populations being addressed.

[1] Office of National Drug Control Policy. (2000). National drug control strategy: 2000 annual report. Washington, DC.

Intervene Early at Important Stages and Transitions

10. Intervene early and at developmental stages and life transitions that predict later substance abuse.

11. Reinforce interventions over time.

Intervene in Appropriate Settings and Domains

12. Intervene in appropriate settings and domains.

Manage Programs Effectively

13. Ensure consistency and coverage of programs and policies.

14. Train staff and volunteers.

15. Monitor and evaluate programs.

Children's Transition Initiative (CTI)

Based on statewide risk and protective factor data, and prevalence data collected through the 1998 Washington State Adolescent Health Behavior Survey, DASA has begun piloting a new Children's Transition Initiative (CTI) in seven counties. Survey data show a sharp rise in youth alcohol, tobacco, and marijuana use between grade school and middle school, and again between middle school and high school. National research findings demonstrate the benefits of providing prevention services to youth over time. These findings provide the basis for CTI, the goal of which is to prevent children, ages 9 to 16, from using alcohol, tobacco, marijuana, and other drugs.

Through CTI, existing county programs will identify discrete youth populations at high risk for drug initiation. Prevention programming will be specifically tailored for each group, depending on their individual risk factors, protective factors, and assets.

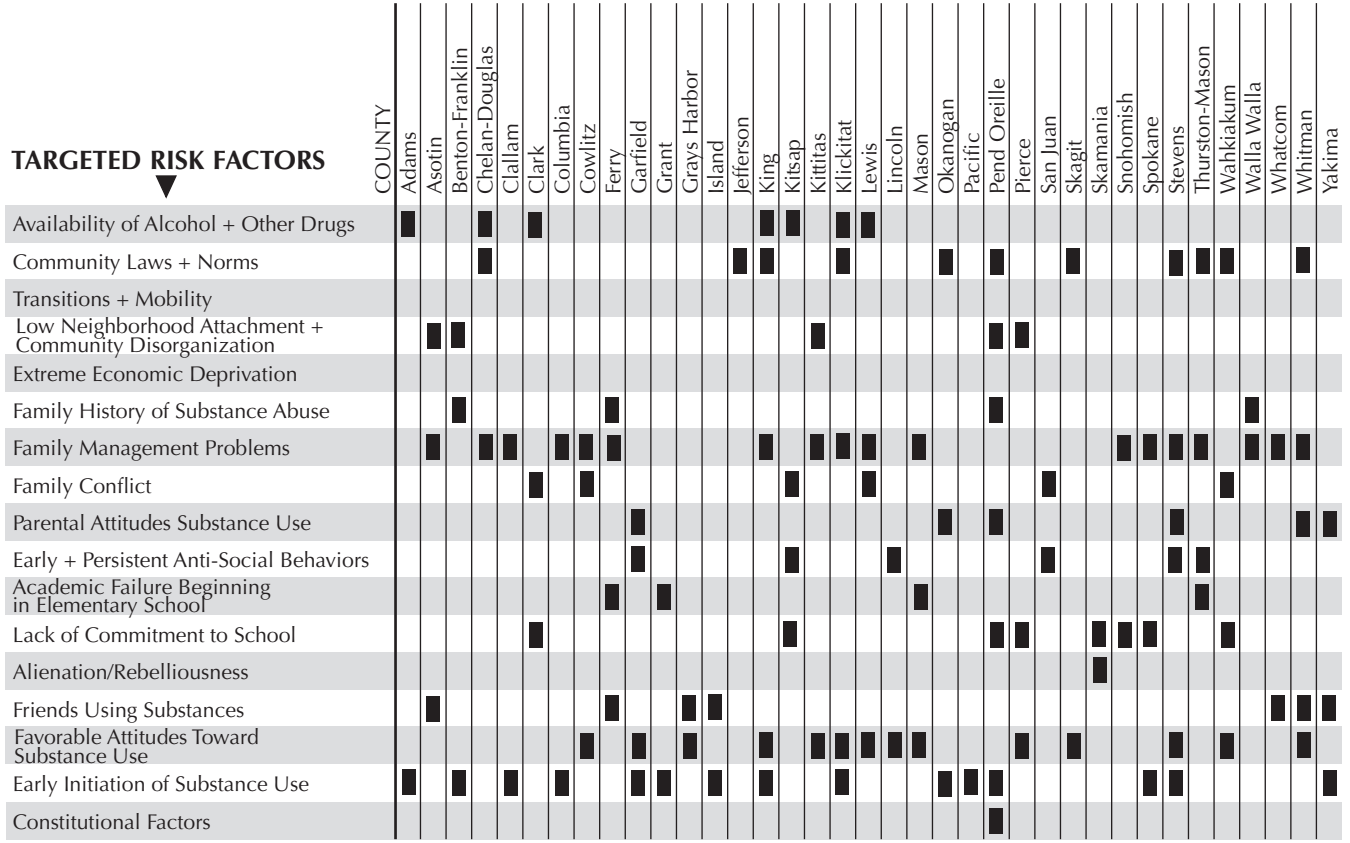
The following primary outcomes have been identified for CTI:

- Enrolled youth will demonstrate a significantly higher rate of abstinence from alcohol, tobacco, marijuana, and other drugs than non-enrolled youth with similar risk factors, protective factors, and assets.
- There will be a 50% increase in the awareness of risk and protective factors associated with substance abuse by parents or caregivers of CTI-participating children.
- 80% of children enrolled in CTI will be retained in the initiative for a minimum of 12 months.

Secondary outcomes will be negotiated between DASA and counties, and may include targeted risk and protective factors in the school, family, peer, or community domains. From July 1999 thru January 2002, 265 children and families have been enrolled in CTI services in the following counties: Benton, Franklin, Columbia, Grant, Island, Lincoln, Spokane, Skamania, Whatcom, Pierce, Lewis, and Clark.

Targeted Risk Factors

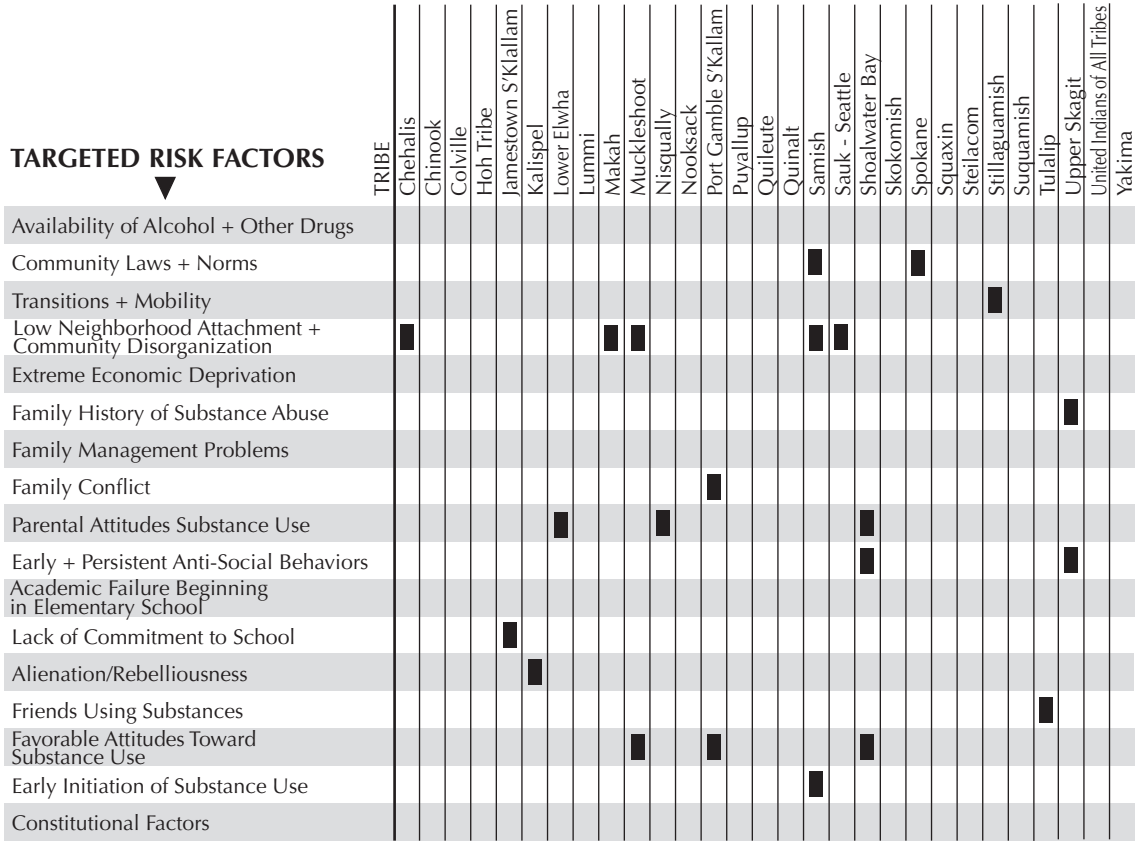
The table below displays a summary of the top targeted risk factors (for the 2001-2003 Biennium) identified by each of the counties in Washington State.



Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.

Targeted Risk Factors

The table below displays a summary of the top targeted risk factors (for the 2001-2003 Biennium) identified by each of the federally recognized Tribes in Washington State.

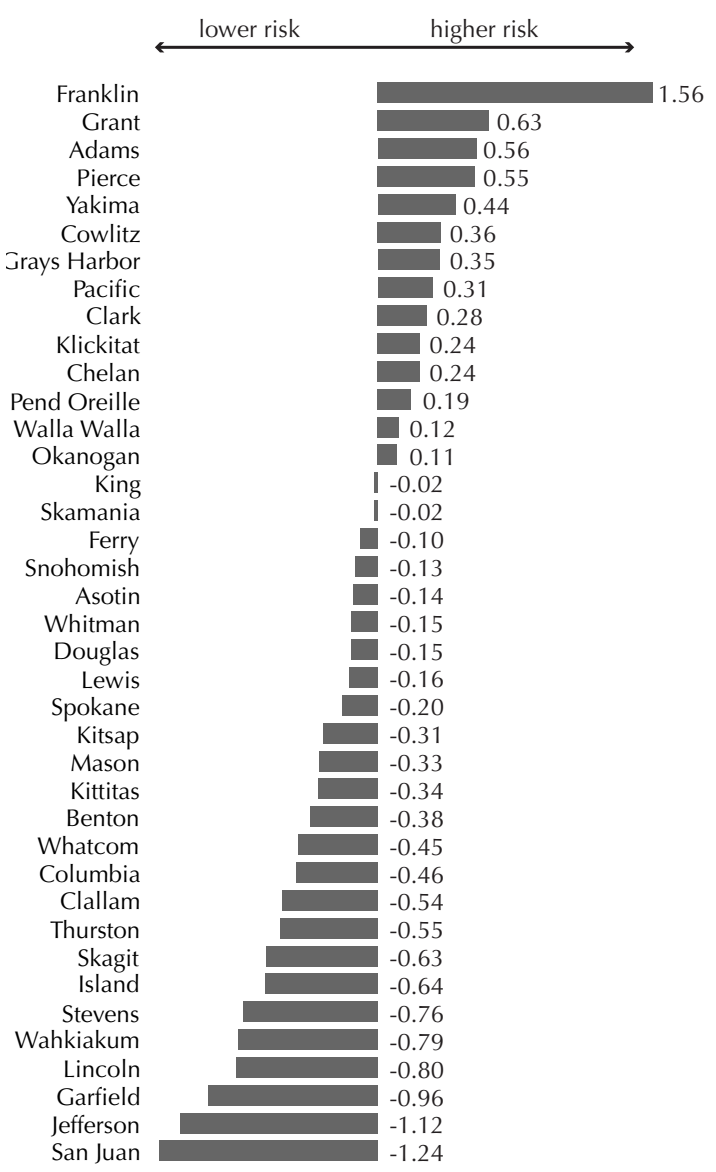


Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.

Risk Factor: Low Neighborhood Attachment and Community Disorganization

In some neighborhoods, people do not feel like there are collective rules or goals by which members live. In these neighborhoods there may be higher rates of juvenile delinquency, less voluntary monitoring or informal surveillance of public spaces, and less willingness to intervene for the public good. A willingness to intervene in support of community principles is based on mutual trust and solidarity. This may be difficult to achieve where neighbors do not know each other, and where individuals do not believe they can change things for the better.

These conditions are most likely to prevail in neighborhoods with high turnover, and especially where there is a falling population and increased residential vacancies. These are often also areas of economic disadvantage due to rising unemployment.

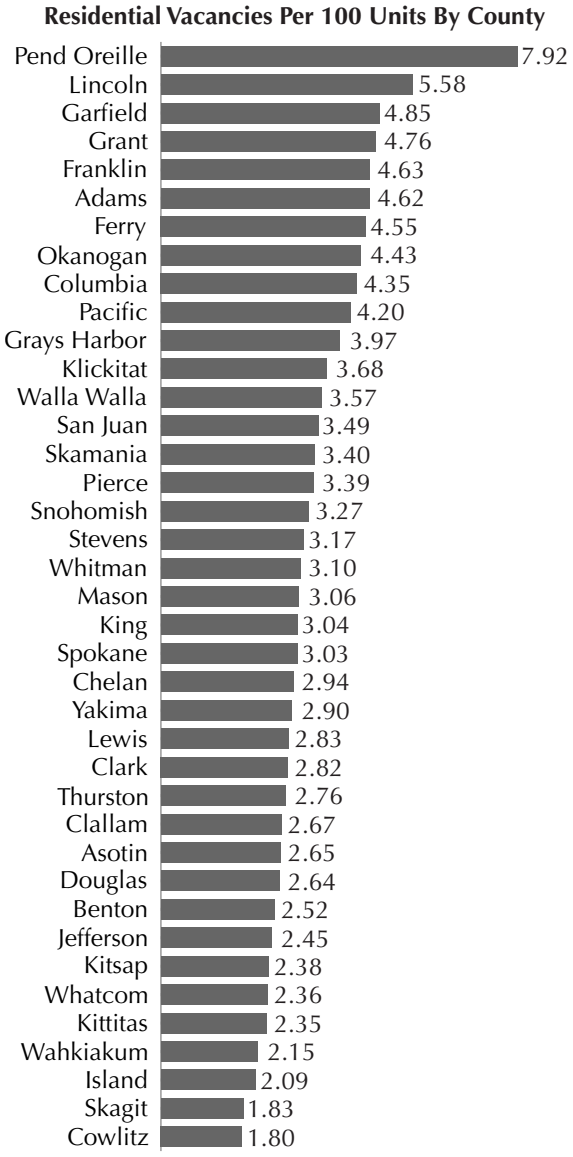


Source: Becker, L., Sandberg, M., Barga, V., & Stanley, M. (2000). Profiles of Risk and Protection for Substance Abuse Prevention Planning in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, and Research and Data Analysis.

Risk Factor: Low Neighborhood Attachment and Community Disorganization – Residential Vacancies

Four indicators based on data gathered from archival sources are used to assess the degree of low neighborhood attachement and community disorganization. These are: population not registered to vote; population not voting in elections; number of community residents within state correctional systems; and residential vacancies.

This graph illustrates the residential vacancy rate per 100 housing units based on data from 1990 U.S. Cenus.



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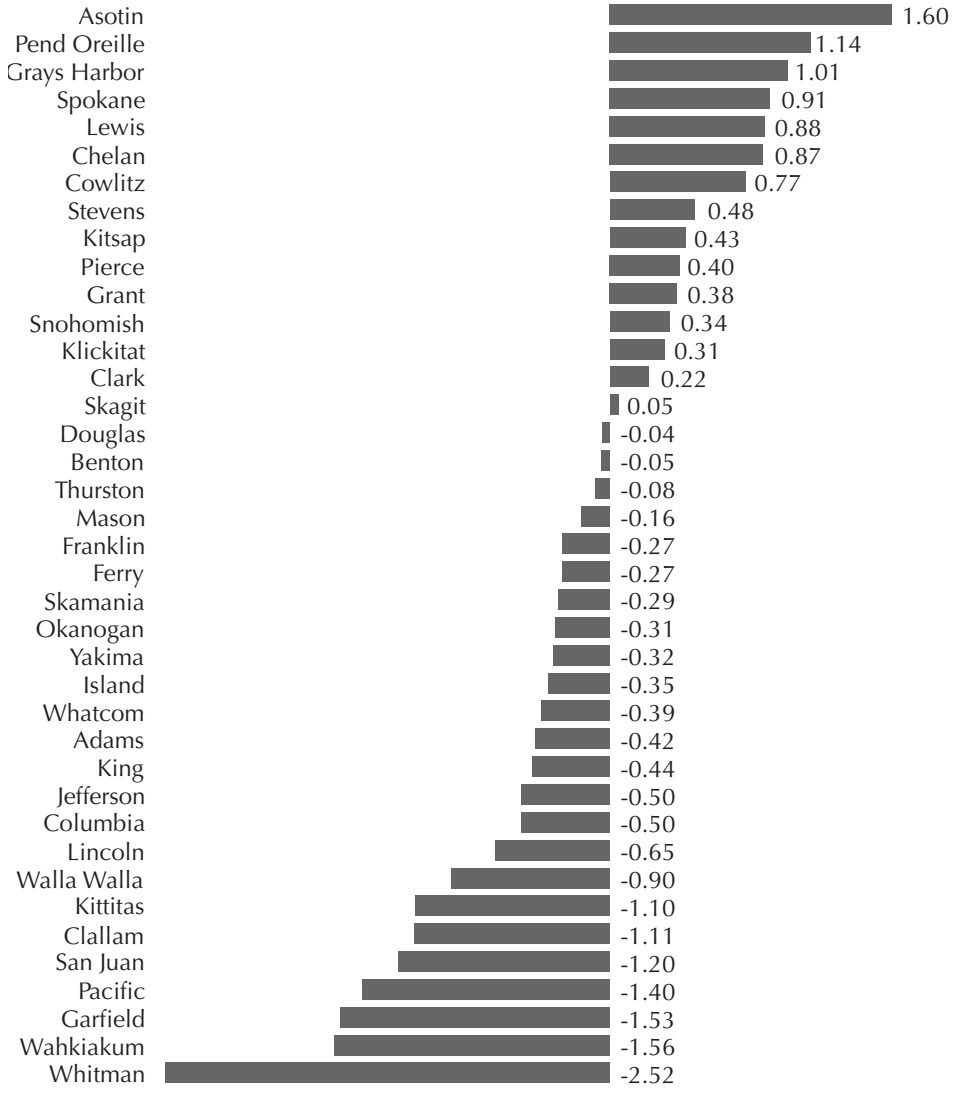
Risk Factor: Family Conflict

Families have the primary reponsibility for ensuring children's safety and for providing the nurturing and guidance children need. Skillful parents help their children navigate the challenges of growing up, and assist them on the way towards becoming competent and caring adults.

Persistent conflict between parents or caregivers, or between parents and children, increases the risk for children in these families. Family conflict is a strong predictor of delinquency and anti-social behavior, including substance abuse.



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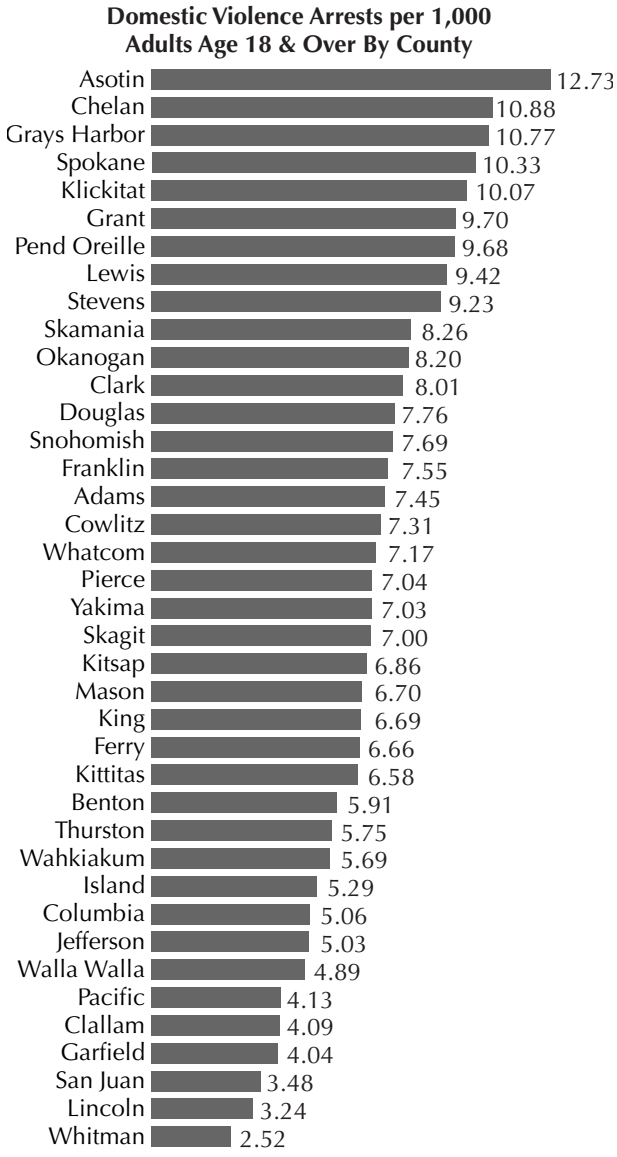
Risk Factor: Family Conflict – Domestic Violence

Two indicators based on data gathered from archival sources are used to assess the degree of family confilict. These are: divorce rates and rates of domestic violence arrests. Domestic violence arrests are a more direct indicator of conflict. However, it should be noted that the rate of domestic vilence arrest can fluctuate based on community and police norms for defining domestic violence and workload constraints. A single well-publicized domestic violence case can lead to an increased number of reports and heightened police vigilance.

This graph illustrates the rate of domestic violence arrests by county.

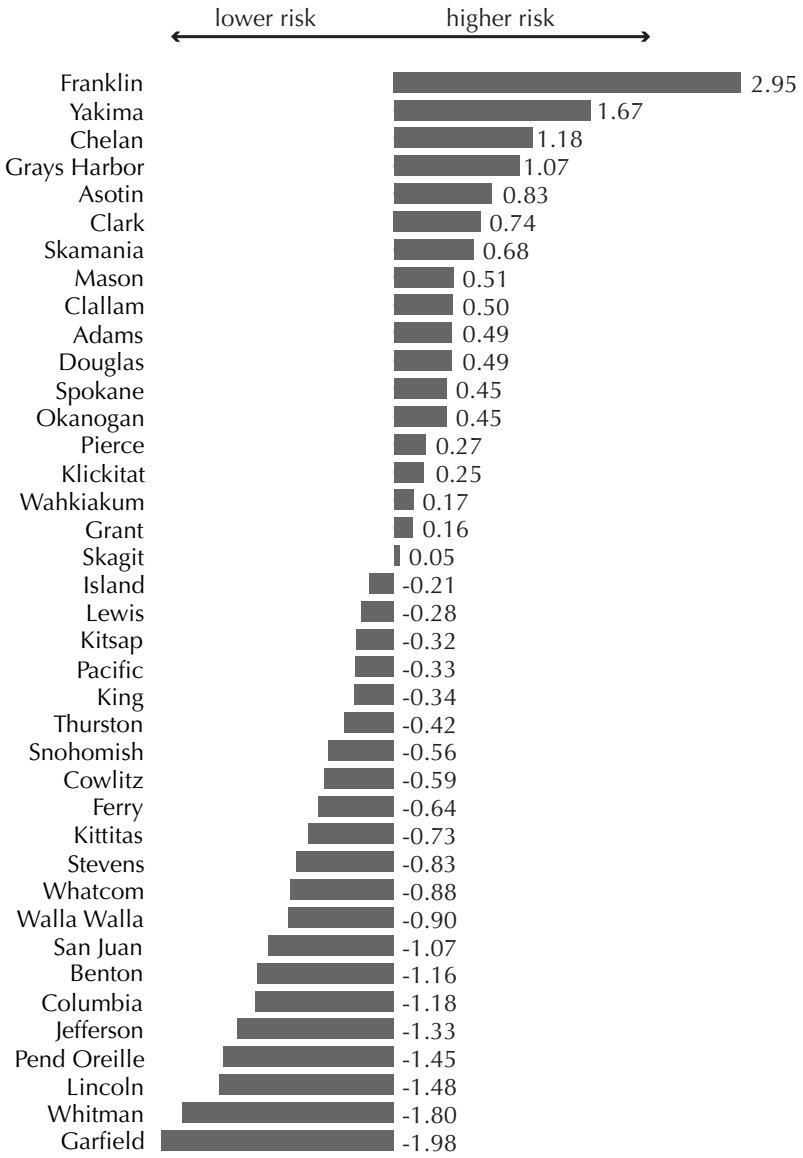


Source: Becker, L., Sandberg, M., Barga, V., & Stanley, M. (2000). Profiles of Risk and Protection for Substance Abuse Prevention Planning in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, and Research and Data Analysis.

Risk Factor: Low Commitment to School

Being able to succeed in school is one of the most important factors in a child's self-confidence and her/his hopes and beliefs about the future. Beginning in the late elementary grades, academic failure increases the risk of both early substance abuse and delinquency.

Research has demonstrated that drug use is significantly lower among students who expect to attend college than those who do not. Factors such as liking school, spending time on homework, and perceiving their coursework as relevant are correlated with lower rates of drug use. When young people cease to see school as meaningful or important in their lives, they are at higher risk of engaging in unhealthy behavior.



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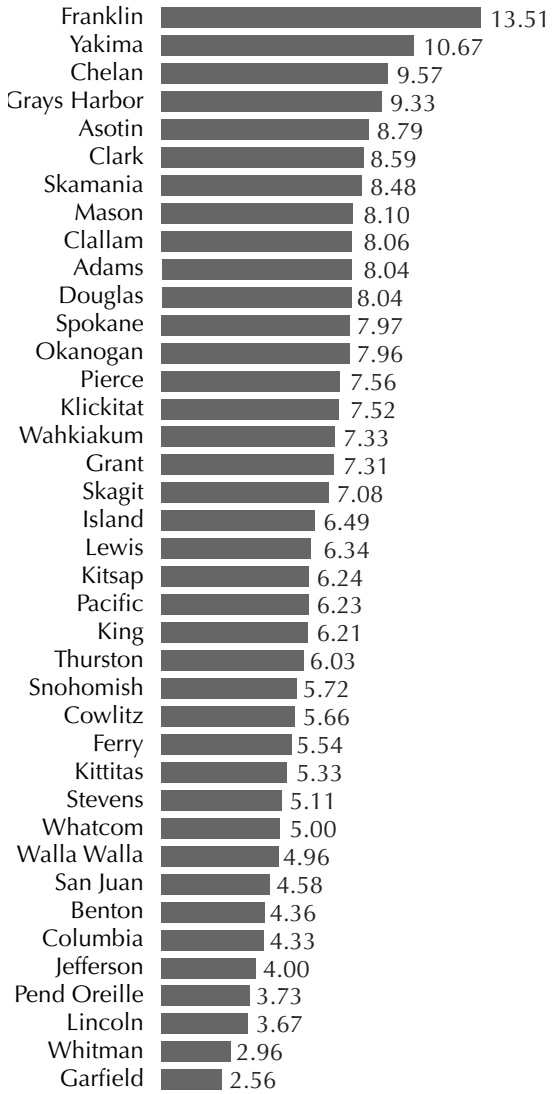
Risk Factor: Low Commitment to School – High School Dropouts

One indicator based on data gathered from archival sources is used to assess low commitment to school: high school dropout rates per 100 students grades 9-12.

This graph indicates high school dropout rates by county, based on data supplied by the Office of the Superintendent of Public Instruction.

High School Dropout Rates Per 100 Students Grades 9-12, By County



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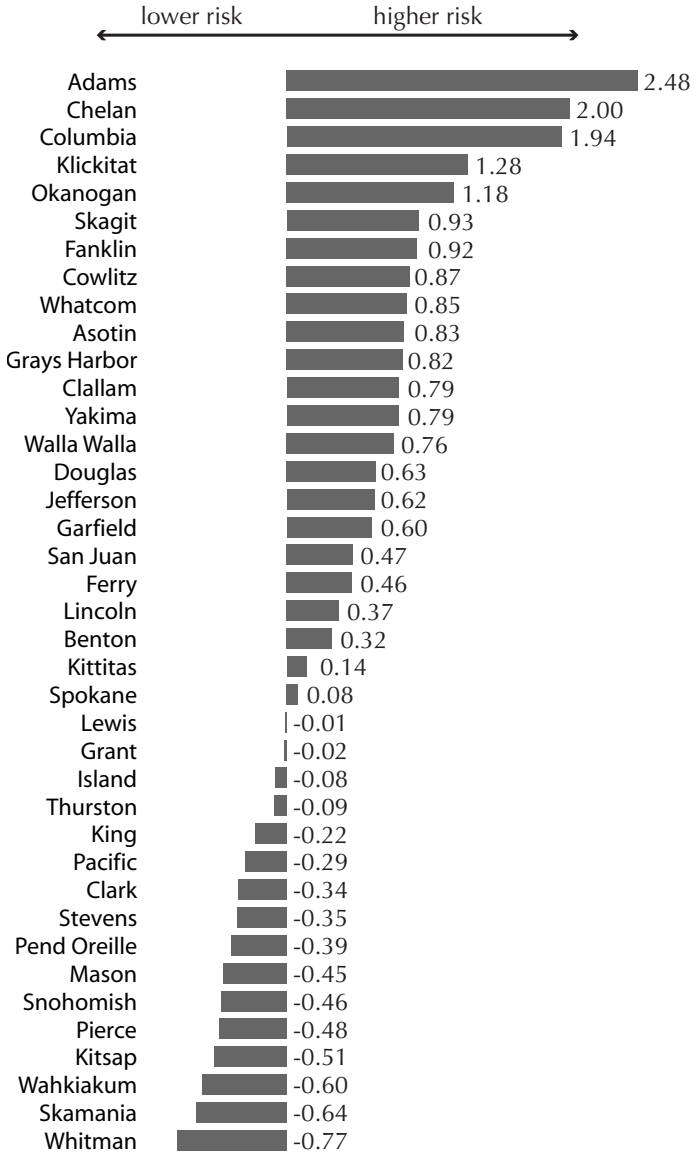
Risk Factor: Early Initiation of Problem Behavior

Early initiation of problem hehavior by young people is a risk factor for continuation or escalation of the behavior when they reach maturity. The younger the age at which youth first use alcohol, tobacco, or marijuana, the more likely it is that they will continue use of these or other substances. Conversely, the longer the delay in age at which young people experiment with substances, the more likely that they will ultimately reject experimentation and use.

Reducing problem behavior means teaching children self-control. It is important for adults, both at home and school, to establish clear rules, monitor and supervise behavior, and reinforce desired conduct. Children are also less likely to intiate problem behavior when they learn how to solve problems and resolve conflicts effectively and consider the effects of their hehavior on others, rather than acting impulsively.

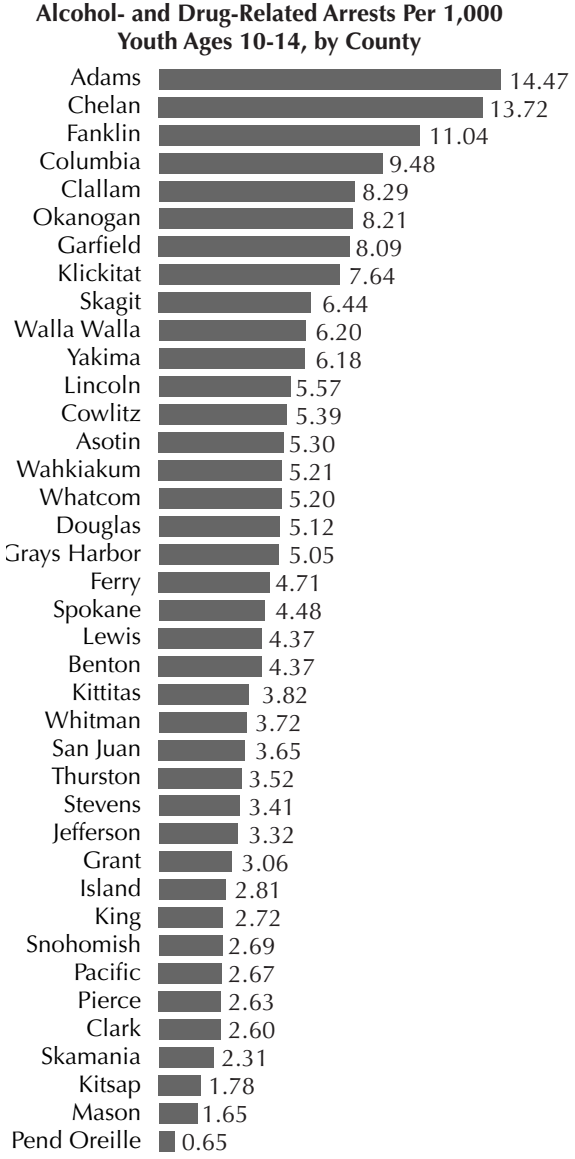


Source: Becker, L., Sandberg, M., Barga, V., & Stanley, M. (2000). Profiles of Risk and Protection for Substance Abuse Prevention Planning in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, and Research and Data Analysis.

Risk Factor: Early Initiation of Problem Behavior – Alcohol- and Drug-Related Arrests

Three indicators based on data gathered from archival sources are used to assess early initiation of problem behavior: rates of alcohol- and drug-related arrests, property crime arrests, and vandalism arrests for youth ages 10-14.

This graph indicates rates of alcohol- and drug-related arrests per 1,000 youth ages 10-14, by county. It is based on data taken from Uniform Crime Reports, 1993-1997.



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Special Prevention Programs

The Division of Alcohol and Substance Abuse is continually involved in a series of prevention programs across the state. Some programs are statewide, while others are county or community specific. Here are just a few of programs DASA currently sponsors:

Public Education Program

DASA supports public education strategies that raise awareness of the harmful consequences of substance use and abuse as a first step in changing attitudes and, ultimately, behaviors. The goals of DASA's program include providing information about the effectiveness of prevention and treatment programs, and connecting parents, youths, and communities with prevention and treatment resources. Components of the program include media literacy education, media advocacy, and multi-media counter-advertising.

Media Program

DASA has developed partnerships with regional television, radio, and newspaper entities as well as local media outlets to promote alcohol, tobacco, and other drug-related prevention messages. Some messages are developed by DASA, while others are provided by the White House Office of National Drug Control Policy, Partnership for a Drug-Free American, and the federal Center for Substance Abuse Prevention.

School-Based Prevention/Early Intervention Program

DASA has established an interagency agreement with the Office of the Superintendent of Public Instruction to administer a statewide school-based program targeting students at risk for developing alcohol, tobacco, and other drug-related problems. Students who are chemically dependent are referred to community-based treatment centers.

Reducing Underage Drinking Initiative

DASA has developed an interagency partnership with the Washington State Liquor Control Board and Washington Traffic Safety Commission to implement a statewide underage drinking prevention initiative. The initiative strives to build community-based partnerships made up of law enforcement, the prevention system, public education, and the juvenile justice system.

Reducing Access to Tobacco Products Partnership

DASA has established an interagency partnership with the Department of Health and the Liquor Control Board to educate tobacco retailers and enforce laws relating to the sale of tobacco products to children.

Alcohol & Drug Information Clearinghouse

DASA contracts with the Washington State Alcohol & Drug Clearinghouse to assist communities, schools, and individuals with access to information about alcohol, tobacco, and other drugs. A statewide toll-free hotline and web-page provides access to printed materials, a video lending library, research reports, posters, and other educational materials.

State Prevention Summit

DASA, in collaboration with other state agencies and statewide prevention organizations, sponsors an annual State Prevention Summit. The Summit brings together over 1,000 participants representing community teams comprised of educators, parents, youth, law enforcement, prevention specialists, and faith community leaders.

College Coalition

DASA has established an interagency agreement with the University of Washington to facilitate the College Coalition. Coalition members administer campus-based prevention programs targeting students and university communities.

Mentoring Initiative

In collaboration with a statewide advisory committee, DASA has established the Washington State Mentoring Partnership. Comprised of mentoring program administrators, service providers, and advocates, the Partnership is implementing a strategic plan for recruiting and using mentors to reach at-risk youth and model, teach, and reinforce positive behavior. DASA provides technical assistance to prevention planners and providers interested in developing local mentoring programs.

School Survey

DASA collaborates with the Office of the Superintendent of Public Instruction (OSPI), Department of Social and Health Services' Division of Research and Data Analysis, Department of Health, and the Office of Community Development to administer a biennial statewide adolescent health behavior survey through local school districts. The alcohol, tobacco, and other drug prevalence data and risk/protective factor information generated from this survey is used by prevention planners and service providers throughout the state.

Drug-Free Workplace Program

DASA contracts with the Washington State Labor Council to assist labor unions in the development of drug-free workplace policies in businesses throughout the state.

Community Prevention Training System

DASA provides training support and funds to county and tribal prevention programs across the state. Interested counties and tribes can receive funding to support training events that enhance their biennial prevention plans.

Washington State Incentive Grant

In July 1998, Governor Gary Locke received a four-year, $8.9 million State Incentive Grant (SIG) awarded by the federal Center for Substance Abuse Prevention. The grant is being used to fund initiatives to reduce youth alcohol, tobacco, marijuana, and other drug use; reduce factors that put youth (grades 4-10) at risk for substance abuse; and enhance factors that provide protection for youth against these risks. The Division of Alcohol and Substance Abuse (DASA) is the agency designated as lead for managing this grant, with Department of Social and Health Services' (DSHS) and Research and Data Analysis (RDA) as the primary evaluator.

Washington State Substance Abuse Prevention System Development Status

In March 2001, Governor Gary Locke issued a document titled *Washington State Incentive Grant State Substance Abuse Prevention System.* This document, prepared by the 32-member Governor's Substance Abuse Prevention Advisory Committee, included signed commitments by the directors of state agencies, councils, commissions, and boards involved in substance abuse prevention "to work together to address Washington State's overarching objectives and institute strategies for a State Substance Abuse Prevention System". Final recommendations for the State Substance Abuse Prevention System are due to the Governor in June 2002.

Participating state entities include the Governor's Executive Policy Office, Office of the Lieutenant Governor, Department of Social and Health Services, Office of the Superintendent of Public Instruction, Office of Community Development, Department of Health, Liquor Control Board, Governor's Juvenile Justice Advisory Committee, Family Policy Council, Washington State Traffic Safety Commission, Governor's Council on Substance Abuse, and Citizen Advisory Council on Alcoholism and Drug Addiction.

State Incentive Grant Objectives

In March 1999, the Governor's Substance Abuse Prevention Advisory Committee, and Governor Locke issued, a Washington State Substance Abuse Prevention Plan. The goal of the Plan is to "streamline state-level prevention systems to coordinate resources and reduce duplication of effort. Below is a table listing the six objectives of the Plan and steps being taken to address them:

Approved March 1999	Approved March 2001
Objective 1 To identify and adopt a set of common outcome measures building on the emerging consensus of a "science-based" risk and protective factor approach to prevention.	**Participating state agencies** reached agreement to work on 18 overarching state outcome objectives and corresponding benchmark objectives. The Governor's Council on Substance Abuse is the lead designated to prepare "report" cards on the progress of reaching the benchmarks every two years.
Objective 2 To develop and coordinate administration of common community needs and resource assessment tools.	**Participating state agencies** reached agreement to expand the existing Community Outcome Risk Evaluation Geographic Information System currently being managed by the Department of Social and Health Services, Research and Data Analysis Division to collect the data necessary to track the overarching state outcome objectives.
Objective 3 To define selection criteria to identify the science-based prevention programs which can best address the needs identified from common assessment and measures.	**The Western Center for the Application of Prevention Technology (WestCAPT)** is the lead for ensuring that community prevention providers have access to current information on science-based prevention programs and programs with promising approaches. At the present time, detailed information is available on CD ROM and via the Internet at http://www.unr.edu/westcapt/.
Objective 4 To develop uniform reporting mechanisms which can capture outcomes of individual community prevention programs.	**The SIG Community Projects** are continuing to field-test a prevention outcome evaluation and monitoring system called *Everest*. The goal is to have this system available to interested prevention providers from participating state agencies and from the community at large. *Everest* is a Web-enabled system that: (1) Generates pre/post tests designed to measure outcomes of participants in prevention programs; (2) Provides a confidential screen for input of the test results; (3) Matches the pre-and post information; and (4) Immediately generates a series of outcome reports.
Objective 5 To develop guidelines for leveraging and redirecting money and resources based on the confidence of the scientifically established outcome measures, uniform community assessments, and reliable reporting.	**Participating state agencies** have achieved tremendous accomplishments through collaboration. In addition to working together on the various aspects of the objectives as described, the state agencies achieved the following: (1) Consolidated administration of school-based adolescent health behavior survey to be administrated every two years in the fall of the second year of the state biennial cycle; and (2) Administrated collaborative community needs assessment that allowed for one assessment to be jointly conducted on the local level and submitted for use by multiple funding state agencies.
Objective 6 To create a system for continuous professional development for all prevention providers, both volunteer and paid.	**The Western Center for the Application of Prevention Technology (WestCAPT)** is the lead for ensuring that community prevention providers have access to training that will prepare them on the most current findings related to prevention and implementation of science-based prevention programs and programs with promising approaches. WestCAPT is developing a state calendar for training opportunities.

In the development of the State Incentive Grant State Substance Abuse Prevention System, 18 objectives were set, and responsibility assigned to those state agencies expected to take the lead in moving the state toward meeting those objectives.

State Incentive Grant Overarching Outcomes and Benchmark Objectives

#	Desired Outcome Objectives	Baseline	Targeted State Benchmarks	Long-range	Short-range	CTED	DOH	DSHS	FPC	GJJAC	LCB	OSPI	WTSC
	SAFETY												
1.	Reduce alcohol-related motor vehicle crash deaths.	1997 4.74 per 100,000	4.0 per 100,000		X			✓			✓		✓
2.	Reduce illicit drug-related deaths.	1998 5.93 per 100,000	3 per 100,000		X			✓					
3.	Reduce the number of young people in Grades 9 through 12 who reported that they rode, during the previous 30 days, with a driver who had been drinking alcohol.	1999 29%	25%	X		✓		✓			✓		✓
4.	Increase the percentage of students reporting that they feel safe in school.	2000 Grade 6 - 86% Grade 8 - 77.4% Grade 10 - 77.5% Grade 12 - 85%	Grade 6 - 90% Grade 8 - 90% Grade 10 - 90% Grade 12 - 90%	X						✓		✓	
5.	Reduce the percentage of youth at risk because they do not perceive communities as having strong laws and norms against substance use.	2000 Grade 6 - 37.5% Grade 8 - 33.3% Grade 10 - 44.1% Grade 12 - 42.3%	Grade 6 - 25% Grade 8 - 25% Grade 10 - 30% Grade 12 - 30%	X		✓	✓	✓			✓	✓	
	SENSE OF BELONGING												
6.	Improve bonding and strong attachment to family. (Data for this objective are available for limited communities in the state, not a representative sample.)	1995 Grade 6 - 83% Grade 8 - 71% Grade 10 - 66% Grade 12 - 70%	Grade 6 - 90% Grade 8 - 80% Grade 10 - 75% Grade 12 - 75%	X		✓		✓		✓			
	SOCIAL INTEGRATION INTO COMMUNITY												
7.	Increase opportunities for pro-social involvement of youth in their community.	1998 Grade 6 - 42.4% Grade 8 - 56.5% Grade 10 - 48.9% Grade 12 - 47.1%	Grade 6 - 75% Grade 8 - 75% Grade 10 - 75% Grade 12 - 75%	X		✓	✓	✓		✓		✓	
8.	Increase rewards for pro-social involvement in the community.	1998 Grade 6 - 67.4% Grade 8 - 52.6% Grade 10 - 55.7% Grade 12 - 51.5%	Grade 6 - 75% Grade 8 - 75% Grade 10 - 75% Grade 12 - 75%	X		✓		✓		✓		✓	

Agency Acronyms: CTED – Community Trade and Economic Development • **GJJAC** – Governor's Juvenile Justice Advisory Committee • **DOH** – Department of Health • **LCB** – Liquor Control Board
DSHS – Department of Social and Health Services • **OSPI** – Office of the Superintendent of Public Instruction • **FPC** – Family Policy Council • **WTSC** – Washington Traffic Safety Commission

#	Desired Outcome Objectives	Baseline	Targeted State Benchmarks	Long-range	Short-range	CTED	DOH	DSHS	FPC	GJJAC	LCB	OSPI	WTSC
	LEARNING AND SKILL BUILDING												
9.	Improve academic achievement for all students.	2000 Grade 4 Grade 7 Grade 10	In development	X		✓						✓	
10.	Reduce the percentage of students at risk due to low commitment to school.	1998 Grade 6 - 35.2% Grade 8 - 39.4% Grade 10 - 42.5% Grade 12 - 47.3%	Grade 6 - 20% Grade 8 - 25% Grade 10 - 25% Grade 12 - 25%	X		✓		✓				✓	
11.	Reduce the number of truant students defined as students who have five unexcused absences in a month or ten unexcused absences in a year.	In development	In development	X						✓		✓	
12.	Increase high school completion rate.	In development	In development	X		✓						✓	
	HEALTH												
13.	Reduce the proportion of youth reporting use during the past 30 days of: • Alcoholic beverages	2000 Grade 6 - 6.6% Grade 8 - 22.3% Grade 10 - 37.6% Grade 12 - 46.8%	Grade 6 - 4% Grade 8 - 15% Grade 10 - 25% Grade 12 - 35%		X	✓	✓	✓			✓	✓	
	• Marijuana	2000 Grade 6 - 1.5% Grade 8 - 12% Grade 10 - 21.9% Grade 12 - 24.4%	Grade 6 - 0% Grade 8 - 5% Grade 10 - 10% Grade 12 - 10%		X	✓		✓					
	• Any illicit drug (includes marijuana)	2000 Grade 6 - 3% Grade 8 - 15.6% Grade 10 - 24.2% Grade 12 - 26.3%	Grade 6 - 0% Grade 8 - 5% Grade 10 - 10% Grade 12 - 10%		X	✓		✓					
	• Cigarettes	2000 Grade 6 - 4% Grade 8 - 12.5% Grade 10 - 19.8% Grade 12 - 27.6%	Grade 6 - 2% Grade 8 - 6% Grade 10 - 10% Grade 12 - 12%		X	✓	✓	✓			✓		
	• Smokeless tobacco	2000 Grade 6 - .8% Grade 8 - 2.1% Grade 10 - 4.6% Grade 12 - 8.8%	Grade 6 - 0% Grade 8 - 1% Grade 10 - 2% Grade 12 - 4%	X		✓	✓	✓			✓		

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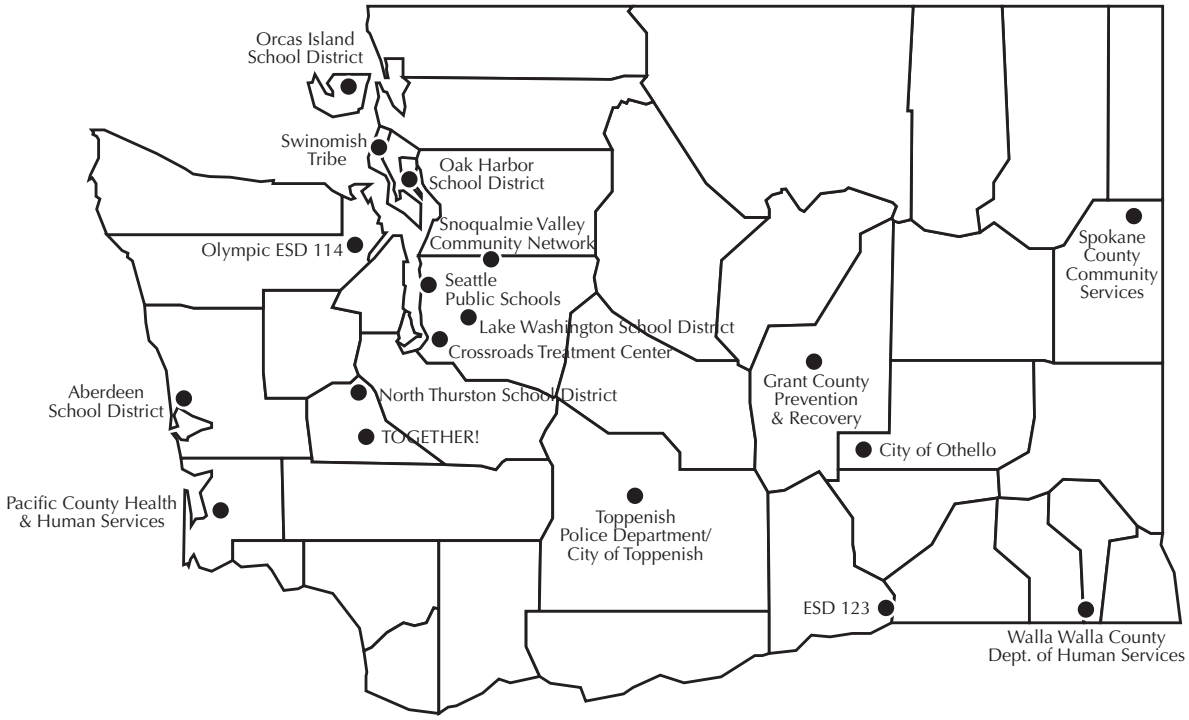
#	Desired Outcome Objectives	Baseline	Targeted State Benchmarks	Long-range	Short-range	CTED	DOH	DSHS	FPC	GJJAC	LCB	OSPI	WTSC
	HEALTH (CONT.)												
14.	Reduce back to 1990 levels, the proportion of youth reporting binge drinking during the past two weeks	2000 Grade 6 - 4.7% Grade 8 - 14.9% Grade 10 - 23.2% Grade 12 - 31.8%	Grade 6 - 4% Grade 8 - 12% Grade 10 - 18% Grade 12 - 20%		X	✓		✓			✓		
15.	Reduce the proportion of (college age), 18- to 24-year-olds reporting sometime in their lives: • Binge drinking	1998 37%	25%										
	• Use of marijuana	18%	15%		X		✓	✓					
	• Use of any illicit drug	21%	17%										
	• Use of cigarettes	37%	25%										
16.	Increase abstinence by pregnant women: • Any use in the past month • Binge drinking • Illicit drugs • Cigarette smoking	In development	In development	X	X	✓	✓	✓					
17.	Increase the percentage of youth who perceive the harmfulness of: • Smoking one or more packs a day	2000 Grade 6 - 87.5% Grade 8 - 90.8% Grade 10 - 93.3% Grade 12 - 94.5%	Grade 6 - 100% Grade 8 - 100% Grade 10 - 100% Grade 12 - 100%	X		✓	✓	✓				✓	
	• Regular binge drinking	2000 Grade 6 - 69.4% Grade 8 - 71.8% Grade 10 - 76.8% Grade 12 - 73.7%	Grade 6 - 100% Grade 8 - 100% Grade 10 - 100% Grade 12 - 100%	X		✓		✓				✓	
	• Regular marijuana use	2000 Grade 6 - 83.3% Grade 8 - 84.6% Grade 10 - 81.3% Grade 12 - 79%	Grade 6 - 100% Grade 8 - 100% Grade 10 - 95% Grade 12 - 95%	X		✓		✓				✓	
18.	Increase the average age of first use of all substances to age 16: • Alcohol	1998 Age 14	Age 16	X		✓		✓					
	• Tobacco	Age 13	Age 16	X		✓	✓	✓					
	• Marijuana	Age 14	Age 16	X		✓		✓					

Agency Acronyms: CTED – Community Trade and Economic Development • **GJJAC** – Governor's Juvenile Justice Advisory Committee • **DOH** – Department of Health • **LCB** – Liquor Control Board
DSHS – Department of Social and Health Services • **OSPI** – Office of the Superintendent of Public Instruction • **FPC** – Family Policy Council • **WTSC** – Washington Traffic Safety Commission

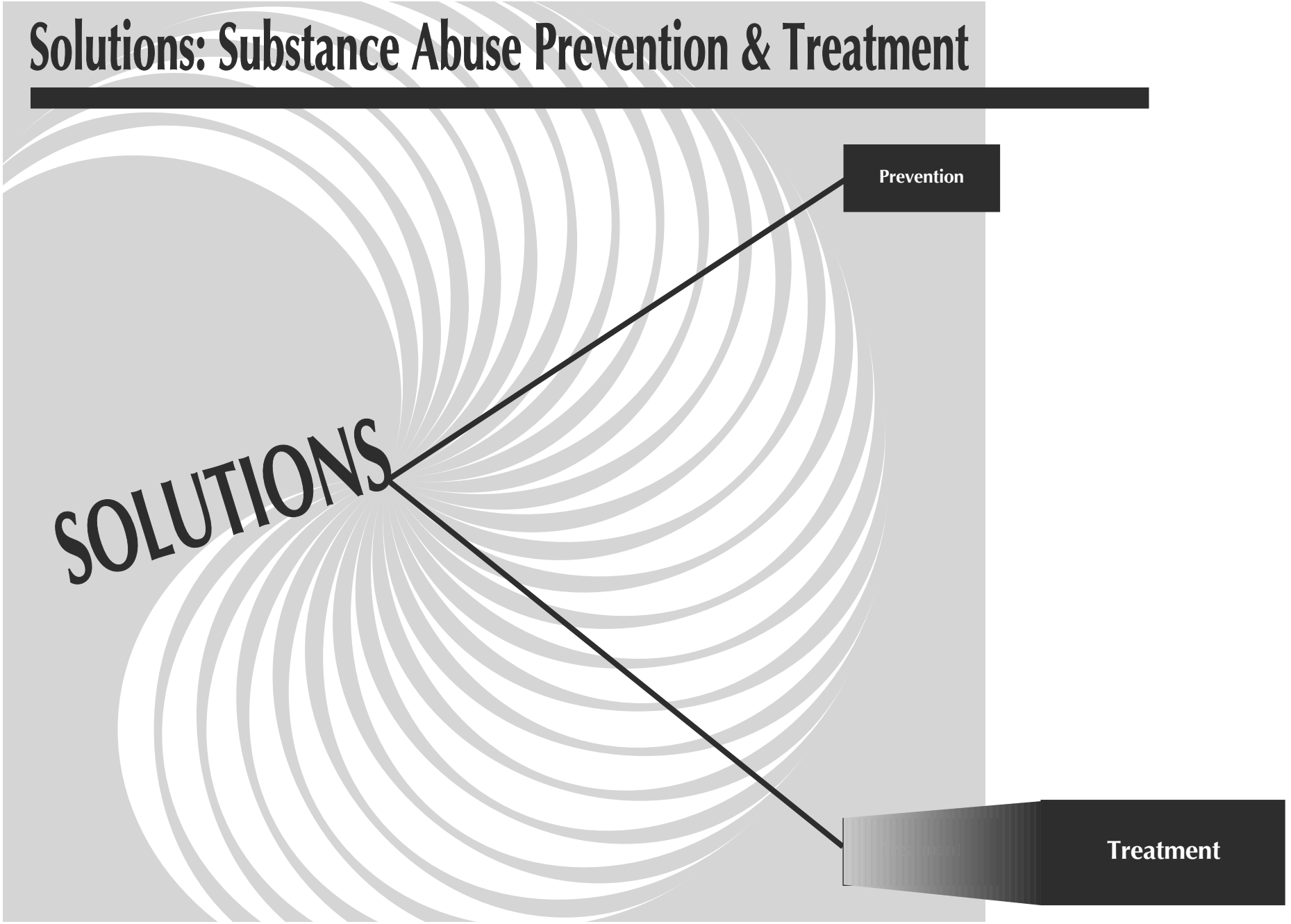
State Incentive Grant Community Projects

For the past three years, 18 community projects in 15 counties received State Incentive Grant (SIG) funding to implement comprehensive prevention services over the course of three years. These projects are implementing community prevention action plans that work to establish community partnerships; use a risk-and-protective factor framework; conduct collaborative assessments at the community level; select and implement activities that have been proven to reduce risk factors and increase protective factors; and participation in rigorous evaluation processes.

Through the process, the projects have established infrastructure to support and enhance science-based programs, and have reduced the number of programs not supported by science in half. Participating community projects include: Othello Prevention Collaboration, Finley School District and Community Prevention Project, Grant County SIG Prevention Project, Aberdeen FAST Program, Stanwood Camano Island Network & Oak Harbor Community SIG Project, King County Eastside Central Community, Jefferson County Prevention Project, Snoqualmie Valley Prevention Project (King County), Southeast Seattle SIG, Pacific County Kid Care, United Communities Coalition of Pierce County, Orcas Island Prevention Project, Spokane Eastside Central Neighborhood Project, Swinomish Tribal Community Project, The Bridge Project: A Substance and Drug Abuse Prevention Program (Thurston County), Kids' Place/Teen Zone (Thurston County), Connecting Kids to Themselves, Their Families, and Their Communities (Walla Walla County), and City of Toppenish Safe Haven.



Solutions: Substance Abuse Prevention & Treatment



Introduction

Individuals are eligible for DASA-funded services if they are low-income or indigent, and are assessed as chemically dependent. For persons applying for treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), eligibility is further restricted to those who are unemployable as a result of their alcohol or other drug addiction. Treatment services are designed to maintain a cost-effective, quality continuum of care for rehabilitating alcoholics and drug addicts.

Contracted treatment services include:

- Diagnostic evaluation
- Alcohol/Drug detoxification
- Outpatient treatment
- Methadone treatment for drug addicts
- Intensive inpatient treatment
- Recovery house
- Long term residential care
- Involuntary treatment of alcoholics
- Youth residential treatment
- Youth outpatient treatment
- Residential treatment for pregnant and parenting women (with child care)
- Outpatient treatment for pregnant and parenting women (with child care)
- Treatment for co-occurring disorders

Specialized contracted support services for eligible individuals include:

- Child care
- Translation services (including interpreters for persons who are deaf or hard of hearing)
- Transportation assistance
- Youth services case management
- Youth outreach
- Cooperative housing (Oxford House) support

State and federal funding requirements give priority for treatment and intervention services to the following:

- Pregnant and postpartum women and families with children
- Families receiving Temporary Assistance for Needy Families (TANF)
- Child Protective Services referrals
- Youth
- Injection drug users (IDUs)
- People with HIV/AIDS

DASA Treatment Philosophy for Alcohol, Tobacco, and Other Drug Addiction

DASA's program of substance abuse services is based on knowledge gained from medical research that alcoholism and addiction to other drugs is a progressive disease. Research and evaluation studies cited throughout this report indicate that long periods of sobriety, abstinence, and/or reduced drug use result from effective intervention and treatment. Research also demonstrates that treatment results in a marked reduction in negative consequences for the addicts, their families, friends, and society at large, as measured by domestic violence, disrupted families, employment histories, and public costs for law enforcement and the courts, welfare dependence, medical and hospital costs, and admissions to psychiatric hospitals.[1] As alcoholism and addiction are chronic, relapsing disorders, continued treatment and support services will be required after any initial course of treatment.

Alcohol, tobacco, or other drug addiction is an individual, family, worksite, and community affliction. These addictions negatively impact all sectors of society regardless of age, education, race/ethnicity, gender, occupation, or socio-economic status. Therefore, it is critical that all citizens – especially teachers, employers, parents, and youth – understand the illness is treatable and the channels for getting a person into private or public treatment agencies. DASA's philosophy recognizes the importance of ensuring all treatment agencies meet established standards for providing services. Treatment must be tailored to the specific needs of each individual, and a continuum of treatment services is essential for matching clients with the optimal types and sequences of treatments. It is also important that specialized treatment services by available for populations with special needs and circumstances, such as adolescents, pregnant and parenting women (and their children), members of minority populations, and those with disabilities.

DASA recognizes that substance abuse treatment cannot occur in isolation from law enforcement and public safety, educational institutions, and social, health, and economic services. It is essential that substance abuse treatment have linkages with all segments of society that are important to recovery and rehabilitation.

A key aspect of DASA's philosophy is recognizing the generational loop of addiction. It is important to break the generational cycle of addiction by promoting alcohol, tobacco, and other drug prevention programs, enrolling children of addicts in appropriate prevention activities, and providing early intervention services when needed.

[1]See, for example: Wickizer, T., and Longhi, D. (1997). Economic benefits and costs associated with substance abuse treatment provided to indigent clients through the Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Olympia, WA: Washington State Department of Social and Health Service, Division of Alcohol and Substance Abuse. See also: Schrager, L. Joyce, J., and Cawthon, L., (1995). Substance abuse, treatment, and birth outcomes for pregnant and postpartum women in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Planning, Research & Development and Office of Research & Data Analysis.

Current Need for Treatment

Defining Current Need for Treatment

Based on a 1999 study conducted by the Department of Social and Health Services, Research and Data Analysis[1] and subsequently updated with current population projections, 418,567 adults (age 18 and older) living in households in Washington State were estimated to be in need of substance abuse treatment in 2001. This represents 9.9% of the population of adults living in households. (The definition of need is provided on the following page.) Treatment need for adolescents (ages 12-17) living in households is estimated at 8.7%.

The largest number of adults in need of treatment experienced an alcohol-related disorder. Among adults, 6.8% (275,906) experienced an alcohol use disorder in the past 18 months, while 1.6% (67,915) experienced a drug use disorder during the same period.

Use rates among adults living in households for individual substances were as follows:

	Lifetime Use	Past 12-Month Use	Past 30-Day Use
Alcohol	92.3%	71.6%*	55.6%
Any Illicit Drug	40.2%	9.8%	4.9%
Marijuana	38.6%	9.0%	4.7%
Stimulants**	16.3%	1.9%	0.8%
Cocaine	12.5%	1.6%	0.5%

*past 18-month use measure utilized for alcohol only
***Includes amphetamine, methamphetamine, and other stimulants.*

[1] Holzer, C., Kabel, J., and Nordlund, D. (1999). Profile of substance use and need for treatment services in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis.

Current Need for Treatment Among Population Subgroups in Washington State

Current estimated need for treatment varies across population subgroups:

- Compared with the overall treatment need rate of 9.9% of adults living in households, some subgroups have lower estimated rates of treatment need. These include: those ages 45-64 (4.9%) and 65+ (2.0%); females (6.3%); Blacks (7.5%), Asian-Pacific Islanders (2.0%), and Hispanics (7.5%); those who are married (6.0%); and non-high school graduates (9.3%).
- Other subgroups have higher estimated need for treatment. These include: those ages 18-24 (24.7%) and 25-44 (12.4%); males (13.5%); Native Americans (American Indians or Alaskan Natives) (17.4%); and those never married (22.0%).

Significantly, need for substance abuse treatment is not highly correlated with income. Compared with need for treatment among all adult household residents (9.9%), 11.1% of adults in households with incomes at or below 200% of the federal poverty line had a current need for substance abuse treatment in 2001.

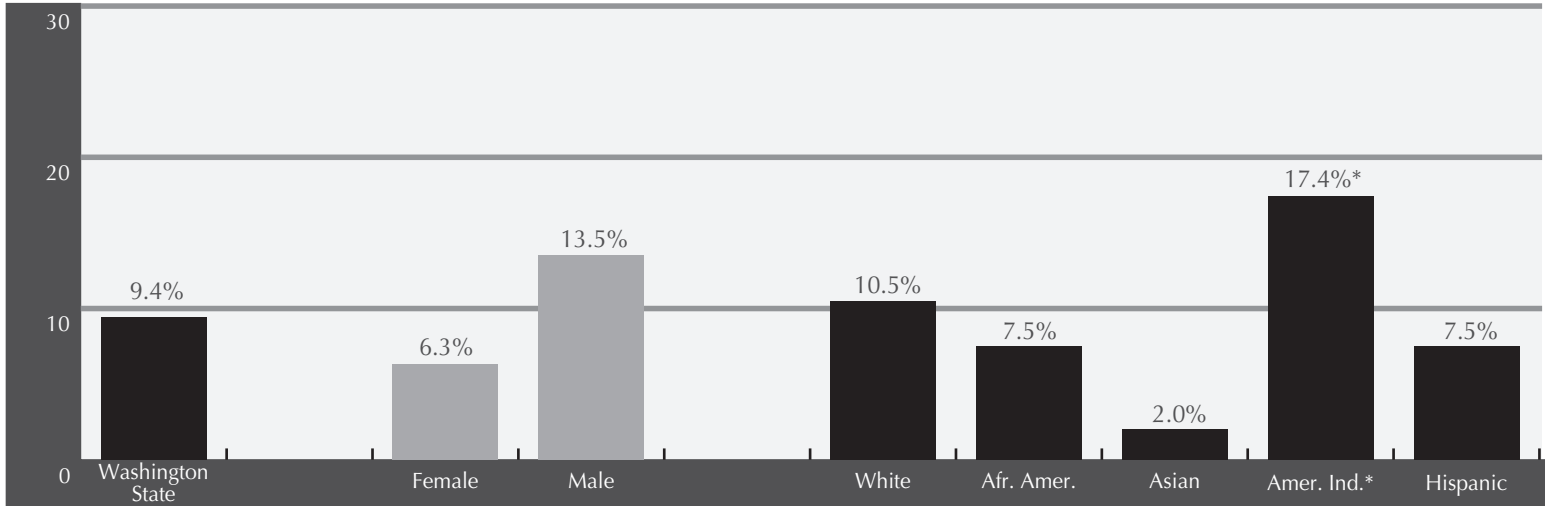
Those defined as currently in need of treatment met one of the following four conditions:

1. Individuals who had a substance use disorder in the past 18 months.
2. Individuals who did not meet the first condition but who reported that they have "had a problem or felt addicted to alcohol or drugs" AND reported drinking or using "regularly" during the past 18 months. "Regular" use means drinking 3 or more drinks per drinking day at least 1 or 2 times a week, OR using marijuana 50 times or more, OR using any other illicit drug 10 times or more.
3. Individuals who did not meet the first two conditions but received licensed residential or outpatient treatment services (excluding detoxification or assessment) during the past 12 months.
4. Individuals who did not meet the first three conditions but used drugs or alcohol "heavily" during the past 18 months. "Heavy" use means drinking an average of 4 drinks per drinking day at least 3 to 4 times per week OR using any illicit drug 50 times during the past 18 months.

Persons Who are Female, Asian, or Hispanic Have LOWER Rates of Current Need for Substance Abuse Treatment. People Who are Male or American Indians* Have HIGHER Rates of Current Treatment Need.

Current Need for Treatment

Percent of Adults in Households



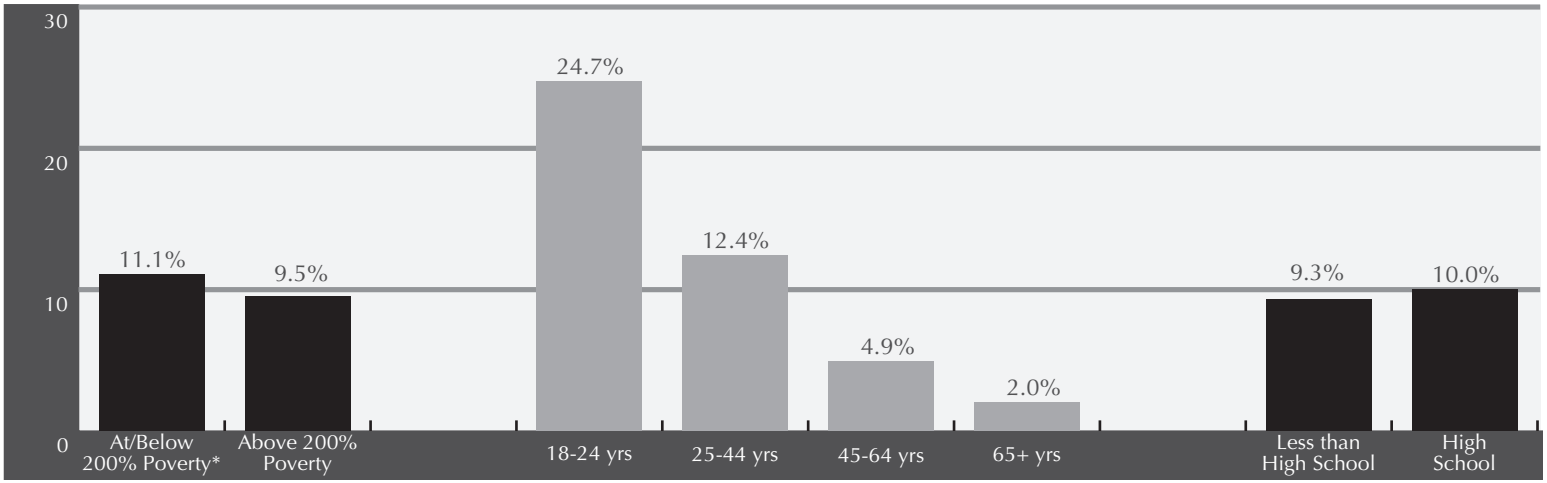
Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999); estimates updated for 2001.

*American Indian includes Alaskan Natives.
Note: for definition of Current Need for Treatment see page 154.

Persons Who are Age 45 and Older Have LOWER Rates of Current Need for Substance Abuse Treatment.

Current Need for Treatment

Percent of Adults in Household



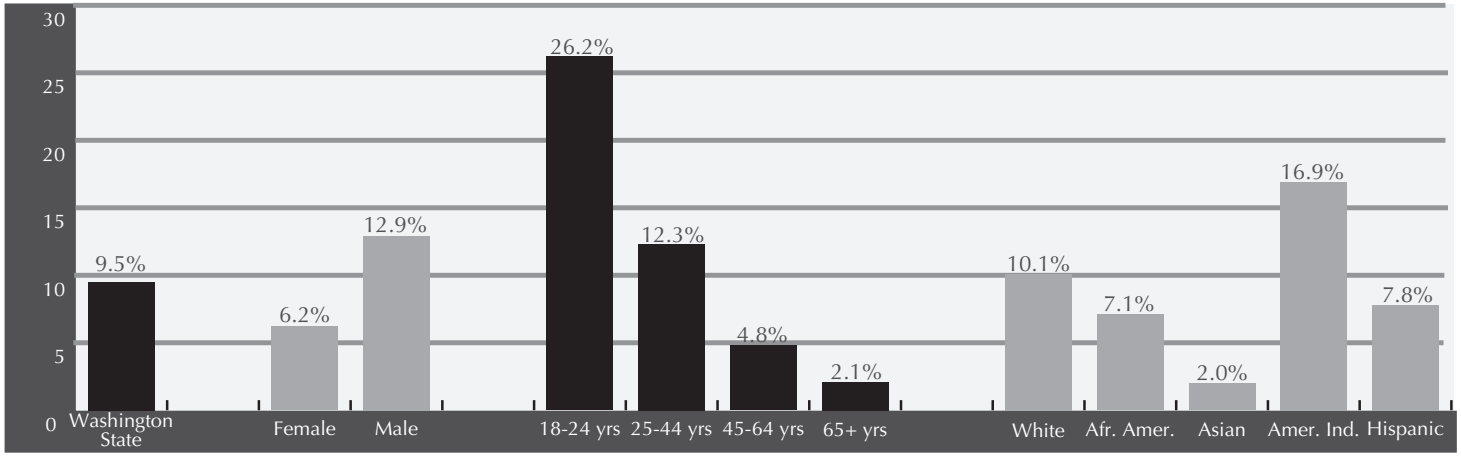
Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999); estimates updated for 2001.

*At/Below 200% of the Federal Poverty Level.
Note: for definition of Current Need for Treatment see page 154.

Adults With Incomes At/Below 200% of the Federal Poverty Level are Slightly More Likely to Have a Current Need for Treatment Than Those With Incomes Above 200% of the Federal Poverty Level.

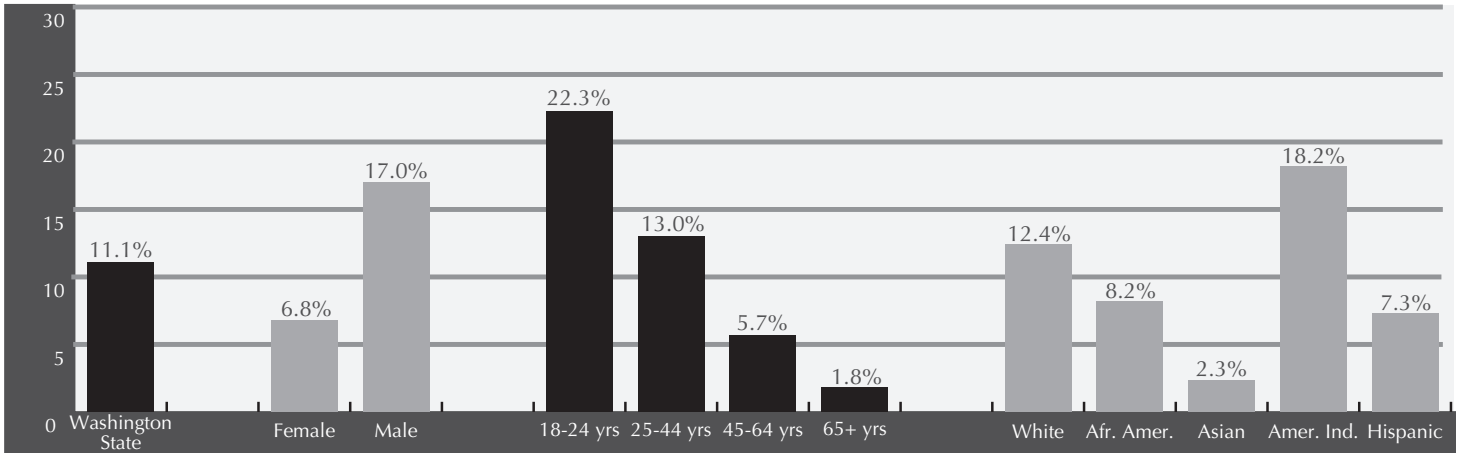
Current Need for Treatment for Adults ABOVE 200% of the Federal Poverty Level

Percent of Adults in Households



Current Need for Treatment for Adults AT OR BELOW 200% of the Federal Poverty Level

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999); estimates updated for 2001.

*American Indian includes Alaskan Natives.
Note: for definition of Current Need for Treatment see page 154.

Computing the DASA Treatment Gap

The Treatment Gap rate is a measure over a given period of time of those who qualify – both clinically and financially -- for DASA-funded treatment services but who, because of the limits of available funding, do not receive it. To compute the treatment gap, an estimate is established of all those at or below 200% of the Federal Poverty Level (FPL) and in need of treatment. Those who are enrolled in the subsidized portion of the Washington Basic Health Plan (BHP) are subtracted from this number. Those receiving BHP with public subsidies would be expected to access chemical dependency treatment services without additional use of DASA funds.

The following equation is then used to compute the DASA Treatment Gap =

$$\textbf{DASA Treatment Gap Rate} = \frac{\text{\# of county residents qualifying for and requiring DASA-funded treatment minus those receiving it}}{\text{\# of county residents qualifying for and requiring DASA-funded treatment}} \times 100$$

The statewide treatment gap is computed by aggregating the county number and using the same formula. Counts of persons receiving DASA-funded treatment were drawn from DASA's TARGET management information service. These counts represent cases that were open in SFY 2001. Individuals must have received at least one residential or outpatient service during this period. Persons receiving more than one treatment service are only counted once.

Only those living in household are included. Those residing in institutions or group care settings are excluded from both the numerator and the denominator.* Results by county and statewide are displayed on the following page.

**For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance. Address and phone number are found on the back cover.*

The Treatment Gap

SFY 2001 Treatment Gap Rates in Washington State

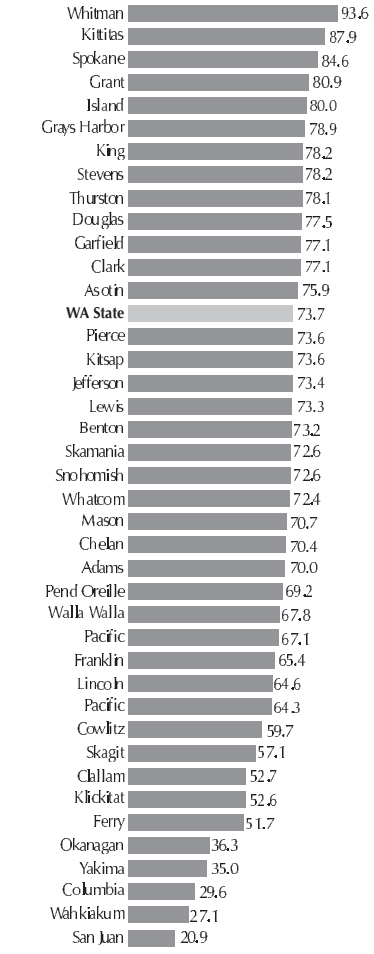
Target Population	Needing & Eligible for DASA-Funded Treatment	Received Treatment with DASA-Funded Support	Number of Eligible Individuals Unserved	Treatment Gap Rate (Unserved Need)
Adults w/children < 18	43,858	10,453	33,405	76.2%
Adults w/o children under 18	52,745	14,942	37,805	71.7%
ALL ADULTS 18 AND OLDER	**96,603**	**25,395**	**71,208**	**73.7%**
ADOLESCENTS (AGES 12 - 17)	**23,554**	**6,098**	**17,456**	**74.1%**
TOTAL	**120,157**	**31,493**	**88,664**	**73.8%**

Excludes detox and transitional housing, private-pay patients, and Department of Corrections.

For information on how the treatment gap was calculated, contact the Office of Planning, Policy and Legislative Relations, Divistion of Alcohol and Substance Abuse (address and phone are to be found on the back cover.)

The Treatment Gap: Statewide, in SFY 2001, 73.7% of Adults in Households Who Qualified for and were in Need of DASA-Funded Treatment Did Not Receive It.

County	Number of Adults <200% FPL & eligible for DASA Services	Percent of Adults <200% FPL & in need of Treatment	Number of Adults <200% FPL Receiving Treatment	Number of Adults Not Receiving Treatment	Treatment Gap
Adams	2,923	7.76%	68	159	70.0%
Asotin	4,136	11.56%	115	363	75.9%
Benton	22,865	10.69%	655	1,789	73.2%
Chelan	14,112	9.76%	407	970	70.4%
Clallam	12,055	9.78%	558	621	52.7%
Clark	46,824	11.11%	1,135	3,798	77.1%
Columbia	858	8.32%	50	21	29.6%
Cowlitz	17,399	10.46%	734	1,086	59.7%
Douglas	6,480	8.64%	126	434	77.5%
Ferry	1,679	12.46%	101	108	51.7%
Franklin	12,760	7.45%	329	622	65.4%
Garfield	342	10.30%	8	27	77.1%
Grant	18,965	8.90%	323	1,365	80.9%
Grays Harbor	15,156	11.39%	364	1,362	78.9%
Island	10,814	11.49%	249	994	80.0%
Jefferson	5,326	10.86%	154	424	73.4%
King	193,820	11.60%	4,893	17,590	78.2%
Kitsap	30,154	11.31%	900	2,510	73.6%
Kittitas	7,664	16.76%	156	1,128	87.9%
Klickitat	4,318	9.47%	194	215	52.6%
Lewis	14,404	10.12%	390	1,068	73.3%
Lincoln	1,542	10.63%	58	106	64.6%
Mason	8,840	10.56%	274	660	70.7%
Okanogan	9,623	10.03%	615	350	36.3%
Pacific	5,011	8.51%	140	286	67.1%
Pend Oreille	2,604	9.97%	80	180	69.2%
Pierce	107,796	10.57%	3,011	8,383	73.6%
San Juan	1,196	10.70%	102	27	20.9%
Skagit	14,201	9.68%	590	785	57.1%
Skamania	2,033	9.37%	52	138	72.6%
Snohomish	61,608	11.33%	1,910	5,070	72.6%
Spokane	80,367	12.80%	1,585	8,702	84.6%
Stevens	7,533	11.04%	181	651	78.2%
Thurston	30,454	11.51%	769	2,736	78.1%
Wahkiakum	641	9.16%	43	16	27.1%
Walla Walla	9,066	11.05%	323	679	67.8%
Whatcom	26,069	14.18%	1,022	2,675	72.4%
Whitman	9,006	19.92%	114	1,680	93.6%
Yakima	48,090	8.37%	2,617	1,408	35.0%
Total	**868,734**	**11.12%**	**25,395**	**71,207**	**73.7%**



For information regarding how these numbers were ascertained, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance Abuse (address and phone are to be found on back cover).

Estimates of Substance Use and Treatment Need in Washington State, 2001

	Entire Adult Population		Adult Household Residents		Adults In Household At or Below 200% of Poverty	
NEED FOR TREATMENT	Number	%	Number	%	Number	%
Current Need for Substance Treatment	450,306	10.4	418,567	9.9	111,003	11.1
ALCOHOL OR DRUG DISORDER						
Lifetime Alcohol or Drug Use Disorder	643,533	14.9	611,238	14.4	154,663	15.5
Past 18-Month Alcohol or Drug Use Disorder	335,150	7.7	309,363	7.3	79,366	8.0
ALCOHOL DISORDER						
Lifetime Alcohol Use Disorder	535,370	12.3	505,120	11.9	116,746	11.7
Past 18-Month Alcohol Use Disorder	309,035	7.1	288,640	6.8	67,852	6.8
DRUG DISORDER						
Lifetime Drug Use Disorder	217,630	5.0	203,746	4.8	67,852	6.8
Past 18-Month Drug Use Disorder	78,347	1.8	67,915	1.6	26,941	2.7
ALCOHOL USE						
Lifetime Use of Alcohol	4,021,809	92.4	3,917,863	92,3	865,116	86.7
Past 18-Month Use of Alcohol	3,125,172	71.8	3,039,208	71.6	574,748	57.6
Past 30-Day Use of Alcohol	2,433,107	55.9	2,360,056	55.6	422,080	42.3
USE OF ANY DRUG						
Lifetime Use of Any Illicit Drug	1,767,158	40.6	1,697,882	40.0	384,163	38.5
Past 12-Month Use of Any Illicit Drug	448,318	10.3	415,981	9.8	110,758	11.1
Past 30-Day Use of Any Illicit Drug	226,336	5.2	207,991	4.9	66,854	6.7
MARIJUANA USE						
Lifetime Use of Marijuana	1,697,517	39.0	1,638,456	38.6	363,209	36.4
Past 12-Month Use of Marijuana	413,498	9.5	382,023	9.0	98,785	9.9
Past 30-Day use of Marijuana	217,630	5.0	199,501	4.7	59,870	6.0
STIMULANT USE						
Lifetime Use of Stimulants	731,238	16.8	691,887	16.3	198,568	19.9
Past 12-Month Use of Stimulants	87,052	2.0	80,649	1.9	29,935	3.0
Past 30-Day Use of Stimulants	39,173	0.9	33,958	0.8	89,304	0.9
COCAINE USE						
Lifetime Use of Cocaine	561,486	12.9	530,588	12.5	126,724	12.7
Past 12-Month Use of Cocaine	73,994	1.7	67.915	1.6	25,943	2.6
Past 30-Day Use of Cocaine	26,116	0.6	21,224	0.5	6,985	0.7

Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999), estimates updated for 2001.

Estimates of Current Need for Substance Abuse Treatment in Washington State, 2001

	Entire Adult Population*			Adult Household Residents			Adults In Household at or below 200% Poverty		
GROUP	**Population**	**# Needing Treatment**	**% Needing Treatment**	**Population**	**# Needing Treatment**	**% Needing Treatment**	**Population**	**# Needing Treatment**	**% Needing Treatment**
Total	4,352,607	450,306	10.4	4,244,705	418,567	9.9	997,827	111,003	11.1
AGE									
01-17	Not Available			Not Availalbe			Not Available		
18-24	558,466	142,163	25.5	515,778	127,187	24.7	192,463	42,820	22.3
25-44	1,729,025	223,250	12.9	1,702,251	210,629	12.4	401,844	52,196	13.0
45-64	1,395,659	70,244	5.0	1,387,291	67,737	4.9	222,993	12,657	5.7
65+	669,457	14,650	2.2	639,385	13,014	2.0	180,527	3,330	1.8
SEX									
Male	2,146,223	309,270	14.4	2,080,698	281,682	13.5	425.910	72,180	17.0
Female	2,206,384	141,037	6.4	2,164,007	136,884	6.3	571,917	38,824	6.8
ETHNICITY									
White	3,688,907	403,324	10.9	3,04,589	377,981	10.5	753,352	93,416	12.4
Black-NH	131,030	12,249	9.4	121,570	9,076	7.5	41,807	3,422	8.2
Asian	242,922	5,179	2.1	238,381	4,888	2.1	69,923	1,627	2.3
Amer. Indian**	58,581	10,733	18.3	56,912	9,925	17.4	26,210	4,770	18.2
Hispanic	231,167	18,822	8.1	223,252	16,697	7.5	106,534	7,769	7.3
MARITAL									
Married	2,655,793	161,962	6.1	2,640,993	159,364	6.0	418,428	29,330	7.0
Div/Sep/Wid	857.042	94,250	11.0	823,543	87,676	10.7	315,506	28,407	9.0
Never Mar	839,772	194,094	23.1	780,169	171,527	22.0	263,893	53,266	20.2
EDUCATION									
Not HS Grad	791,081	77,157	9.8	762,501	70,897	9.3	328,954	19,657	6.0
HS Graduate	3,561,526	373,149	10.5	3,482,204	347,670	10.0	668,872	91,346	13.7
POVERTY									
Below 200%	1,101,288	141,581	12.9	997,827	111,003	11.1	997,827	111,003	11.1
Above 200%	3,251,319	308,725	9.5	3,246,878	307,563	9.5	-	-	-
RESIDENCE									
Residential	4,244,705	418,567	9.9	4,244,705	418,567	9.7	997,827	111,003	11.1
Institutional	51,321	17,706	34.5	-	-	-	-	-	-
Group quarters	56,581	14,033	24.8	-	-	-	-	-	-

*Includes institutions and group quarters

**American Indian includes Alaskan Native.

Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999), estimates updated for 2001.

Treatment Admission Trends

Modality categories are defined as follows:

Detoxification

Detoxification is a short-term residential service for individuals withdrawing from the effects of excessive or prolonged alcohol or drug abuse. Services continue only until the person recovers from the transitory effects of acute intoxication. Detoxification always includes supervision and may include counseling and/or medical care and use of pharmacological agents. Some counties provide detoxification in specialized freestanding facilities; in other counties, detoxification is provided in community hospitals.

Intensive Inpatient

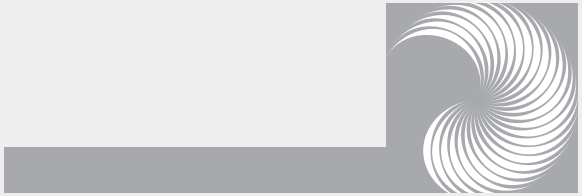
Intensive inpatient treatment is a highly structured program for chemically dependent persons in a residential setting. Services emphasize alcohol and drug education and individual and group therapy. The length of stay in intensive inpatient treatment for adults is based on American Society for Addiction Medicine (ASAM) criteria.

Recovery House

Recovery houses provide social, recreational, and occupational therapy as well as treatment in a drug/alcohol-free residential setting. The program emphasizes helping patients re-enter the community and the outpatient phase of treatment.

Long-Term Residential

Long-term residential treatment is a specialized program for chemically dependent persons who require periods of treatment in excess of 90 days. It includes domiciliary care, counseling, and other therapies to patients who resides at the treatment facility.



Other Residential

This category includes transitional housing, residential treatment for co-occurring chemical dependency and mental health disorders, and on-site group care enhancement services for youth.

Transitional housing provides pregnant and parenting women who have completed chemical dependency treatment with up to 18 months of housing. In conjunction with the housing component, women receive case management services that monitor participation in off-site treatment, prepare clients for self-sufficiency, and link women and their children to other needed services.

Co-occurring disorders programs are provided in residential chemical dependency treatment facilities. Utilizing a group care enhancement model, mental health professionals at the facilities provide assessment, education, in-service training for staff, and linkages to mental health providers in the community.

Through group care enhancement contracts, adolescent chemical dependency treatment providers are able to deliver on-site services to children residing in Department of Social Services children's residential facilities. These include select group homes operated by the Division of Children and Family Services, the Mental Health Division, and the Juvenile Rehabilitation Administration. Providers are able to provide individual drug and alcohol assessments; individual, group, and family treatment; prevention and education groups; training of residential agency staff; case planning and consultation, and linkages to other community alcohol and drug services.

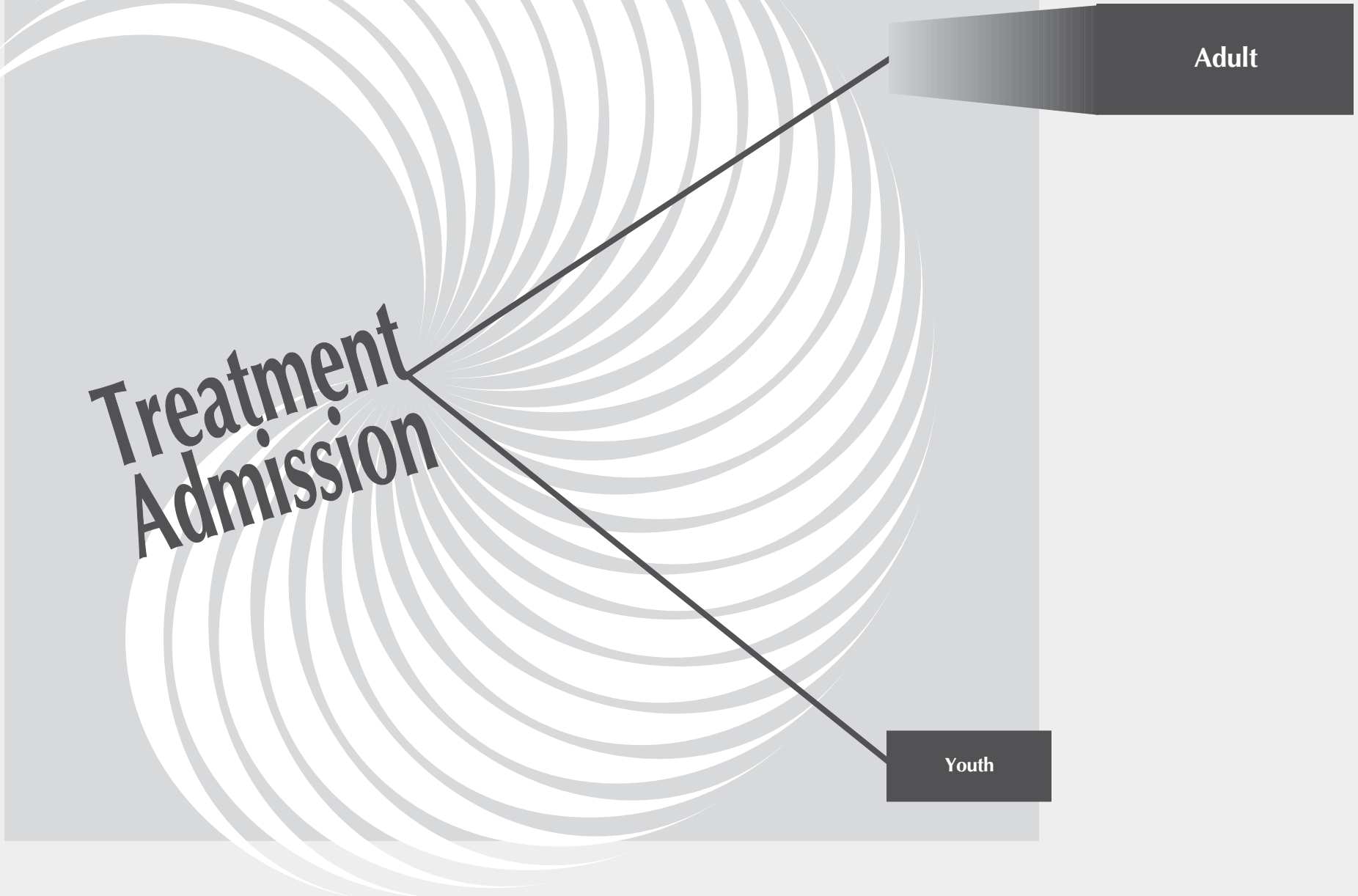
Outpatient and Intensive Outpatient Treatment

Outpatient treatment services consist of a variety of diagnostic and treatment services provided according to a prescribed treatment plan in a non-residential setting. Outpatient treatment provided for indigent patients under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) includes vocational counseling and other efforts to help patients regain employment.

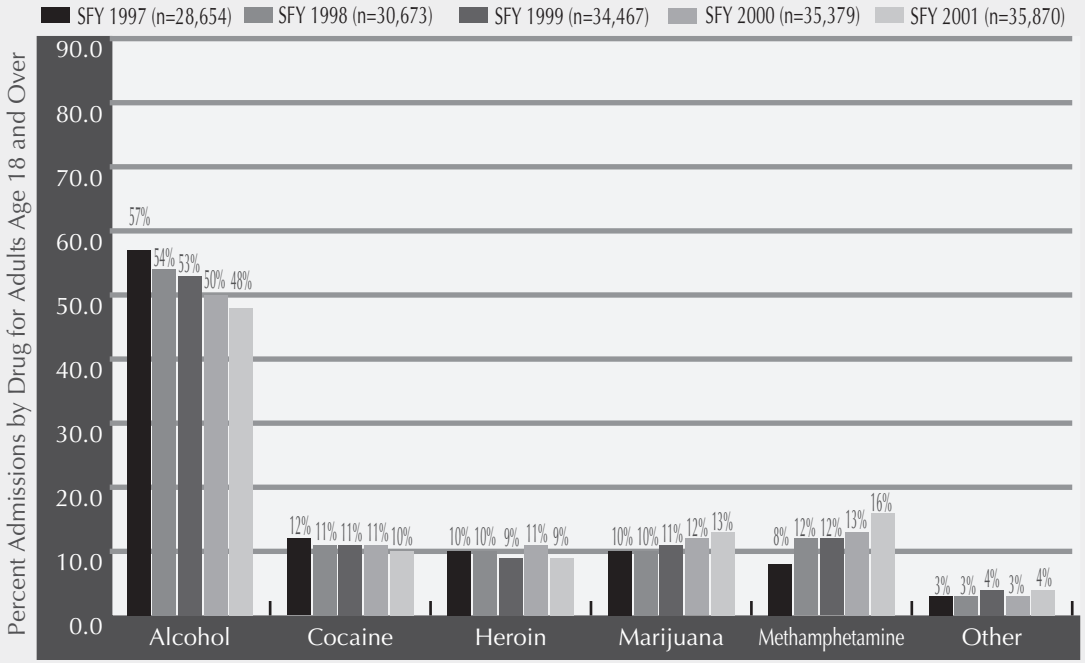
Opiate Substitution Treatment

Opiate substitution treatment is an outpatient service for individuals addicted to heroin or other opiates. State-funded and accredited opiate substitution treatment agencies provide counseling and daily or near-daily administration of methadone or other approved substitute drugs.

Treatment Admission Trends



Alcohol is Cited as the Primary Drug of Abuse in the Plurality of Adult Admissions to DASA-Funded Treatment.*



Source: Treatment and Assessment Report Generation Tool (TARGET), Department of Social and Health Services, Division of Alcohol and Substance Abuse.

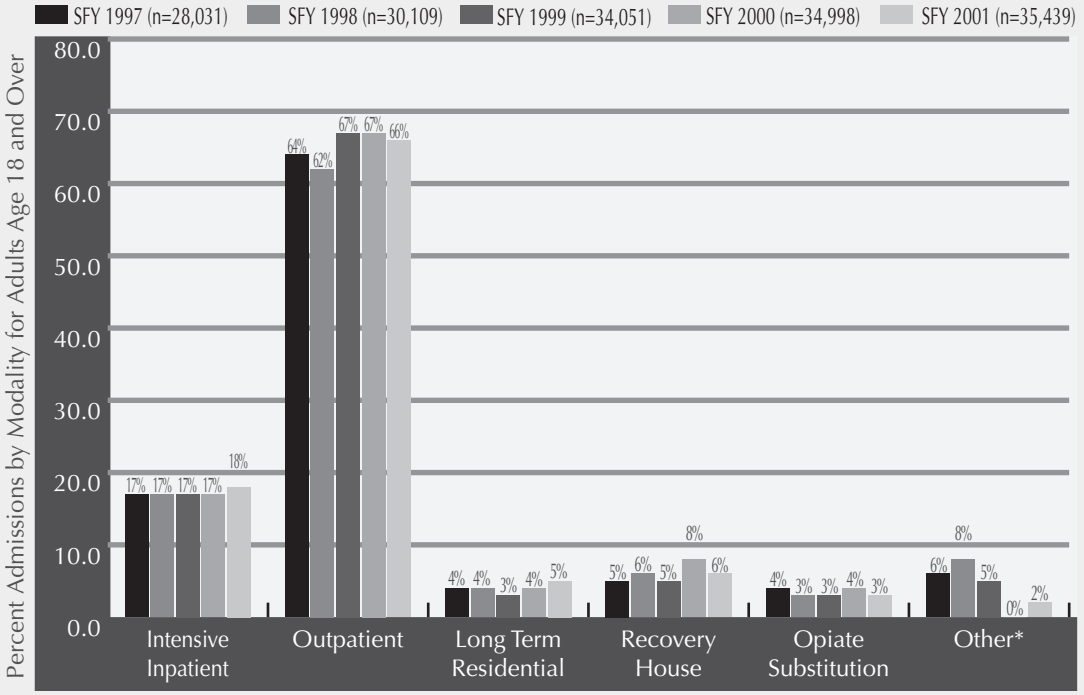
This graph indicates that in SFY 2001, alcohol was the primary drug of abuse for a plurality of adult admissions to DASA-funded treatment. However, while the number of alcohol-related admissions remained stable between SFY 1997 (16,419) and SFY 2001 (17,129), alcohol-related admissions as a percentage of total admissions has now dropped below 50% for the first time in ten years.

Overall adult admissions to treatment have risen 25.2% in the past five years. Admissions for methamphetamine have more than doubled, from 2,334 is SFY 1997 to 5,907 in SFY 2001. It should be noted than many methamphetamine users are poly-drug abusers. Marijuana-related admissions have risen 75.1% in the past five years.

Note: These may include some multiple admissions for a single individual over the course of a year.

** excludes detoxification and transitional housing*

About Two-Thirds of Adult Admissions to DASA-Funded Chemical Dependency Treatment are for Outpatient Services.



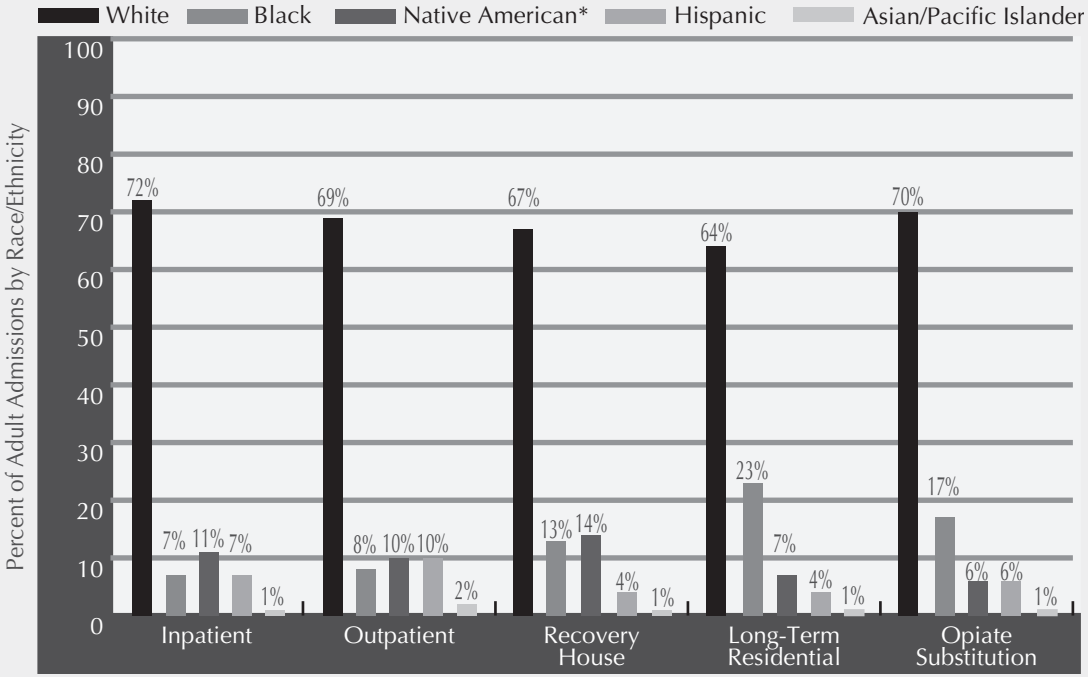
Source: Treatment and Assessment Report Generation Tool (TARGET), Department of Social and Health Services, Division of Alcohol and Substance Abuse.

This graph indicates that almost two-thirds of adult admissions to DASA-funded chemical dependency treatment are for outpatient services (including intensive outpatient treatment.) The number of admissions for intensive inpatient treatment has risen by 19.7% since SFY 1997, representing an overall increase in treatment admissions.

Note: This data may include multiple admissions for the same individual over the course of the year.

**"Other" includes group care enhancements and treatment services for those with co-occurring disorders. Prior to 2000, "Other" included "Extended Care", a modality that has now been phased out.*

In SFY 2001, Racial and Ethnic Minorities Comprised Between 28-36% of Adult Admissions to DASA-Funded Chemical Dependency Treatment Services.



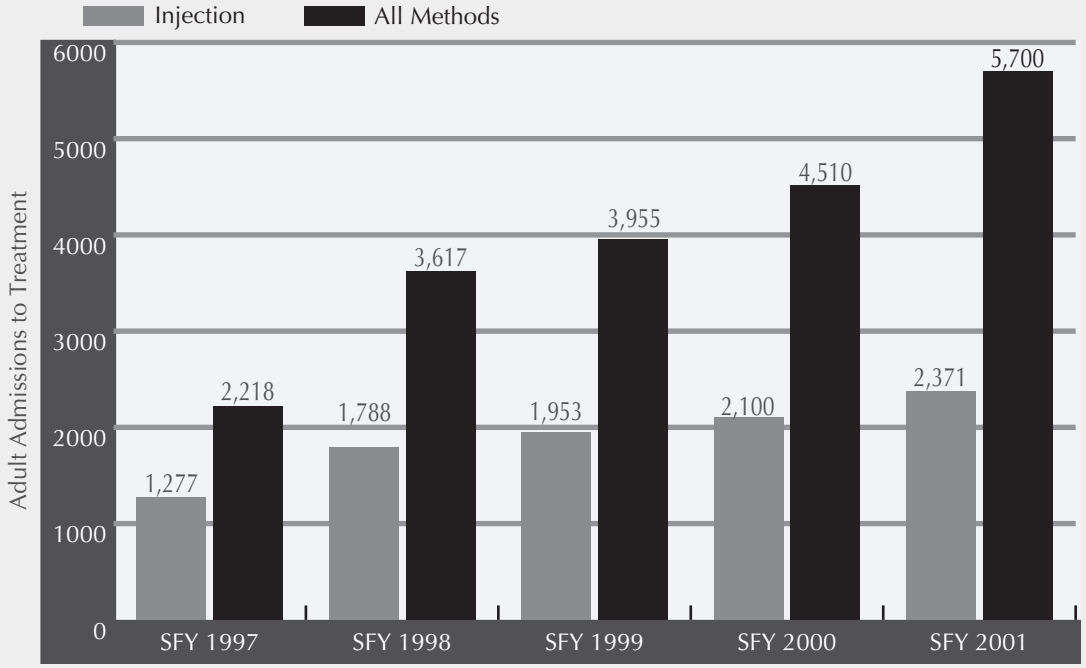
Other races/ethnicities comprise approximately 1% in each modality.

Treatment Assessment Report Generation Tool (TARGET), Department of Social and Health Services, Division of Alcohol and Substance Abuse.

This graph indicates that racial/ethnic minorities comprised between 28-36% of adult admissions to DASA-funded chemical dependency treatment services. Percentages of adults from different minority groups receiving DASA-funded treatment vary across modalities.

**Includes Eskimo/Alaskan Native/Aleut*

DASA-Funded Adult Treatment Admissions for Methamphetamine Use Have More than Doubled in the Past Five Years.

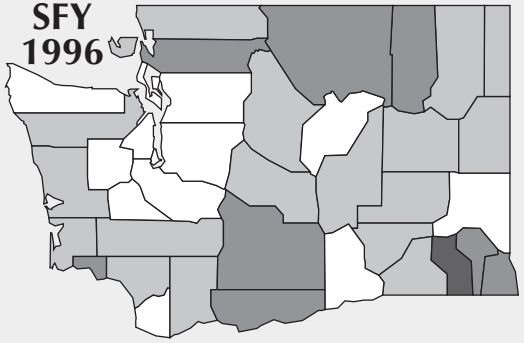


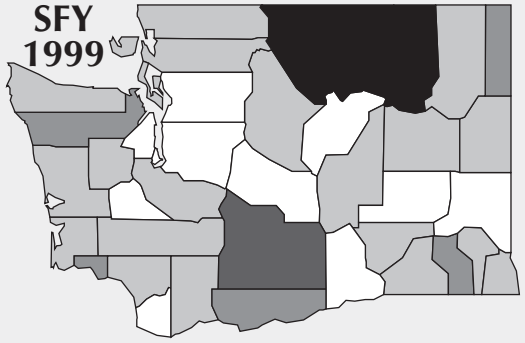
Treatment and Assessment Report Generation Tool (TARGET), Washington State Department of Social and Health Services.

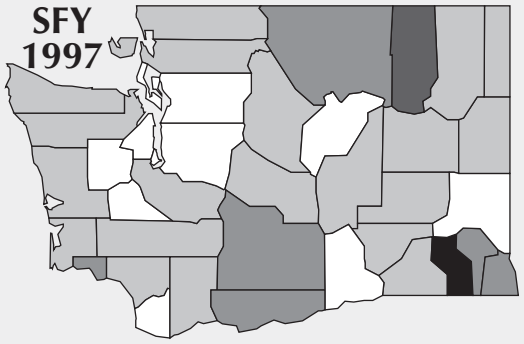
This graph indicates that there has been a significant upward trend in DASA-funded treatment admissions for methamphetamine use over the past five years. While the number of admissions reflecting injection use of methamphetamine has also risen substantially, the percentage reporting injection use has declined from 57.6% in SFY 1997, to 41.6% in 2001. Injection drug use is closely associated with transmission of HIV and hepatitis B and C.

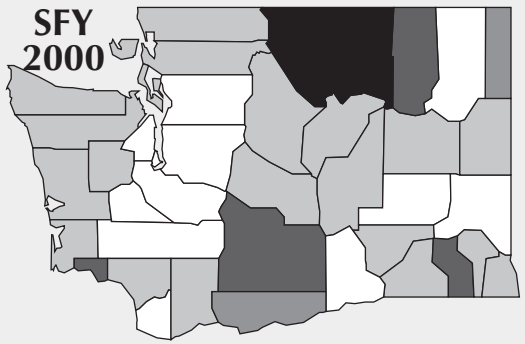
Note: Excludes detoxification and transitional housing, private-pay and Department of Corrections admissions. Includes total unduplicated admissions within counties.

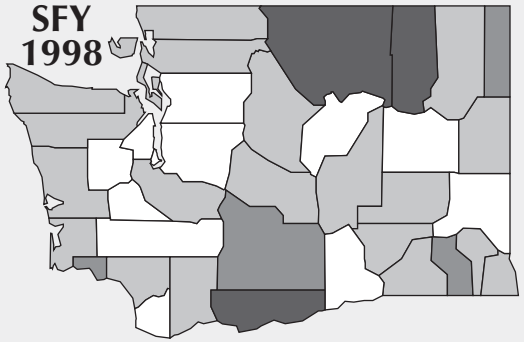
Washington State Adult Treatment Admissions for Alcohol Per 100,000 in Population

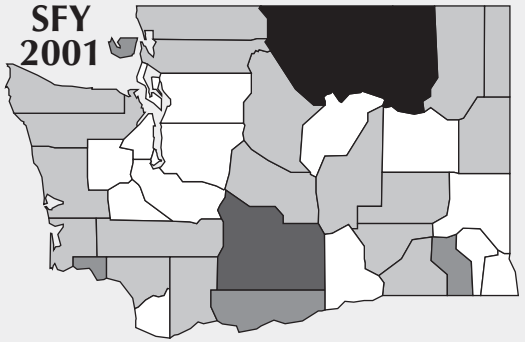


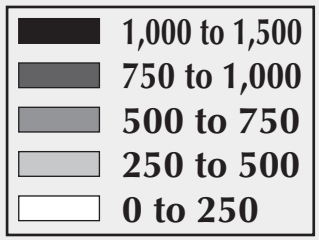












Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

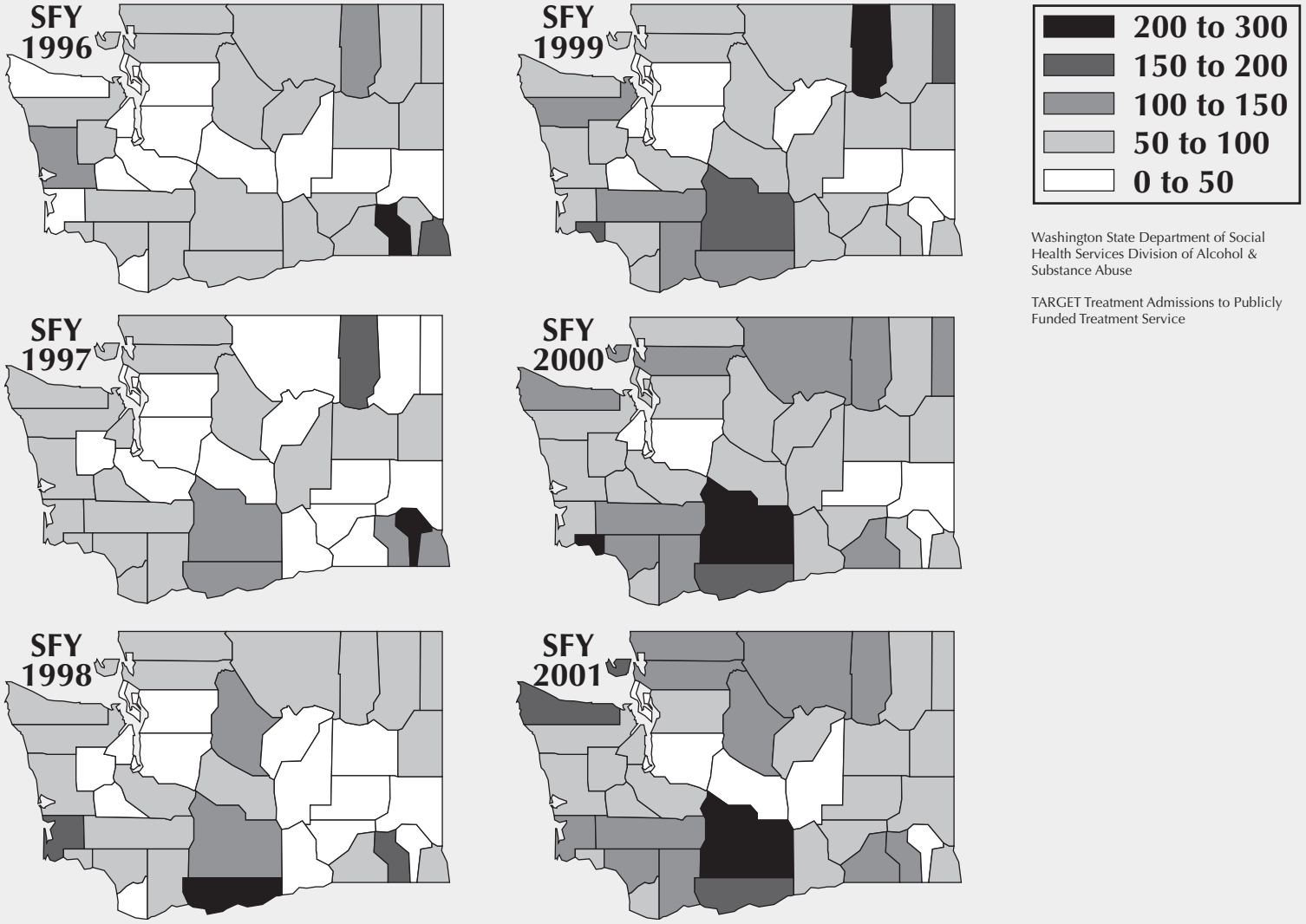
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Adult Treatment Admissions* Primary Drug = Alcohol

County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	55	350.9	51	319.0	41	254.8	39	240.9	30	182.6	43	259.0
Asotin	119	593.4	116	572.2	72	346.4	64	310.5	63	306.6	49	236.7
Benton	270	202.6	249	182.4	261	189.3	322	229.3	300	210.6	309	213.4
Chelan	289	445.3	295	447.4	282	424.6	279	417.0	310	465.4	259	386.0
Clallam	121	194.1	226	359.4	257	405.1	261	405.5	268	415.3	319	492.3
Clark	684	224.7	700	220.6	704	214.8	600	177.7	629	182.2	718	203.6
Columbia	41	859.2	56	1,237.0	27	602.1	32	749.1	32	787.4	24	585.4
Cowlitz	287	318.7	334	368.1	270	294.7	366	394.8	425	457.2	440	468.6
Douglas	71	232.5	61	195.2	62	193.5	71	218.3	85	260.7	74	225.6
Ferry	45	631.1	70	982.2	62	880.4	100	1,375.3	69	950.4	79	1,082.2
Franklin	171	368.8	182	385.5	177	370.7	174	360.2	171	346.5	178	353.2
Garfield	15	693.2	14	621.7	8	351.0	9	376.9	7	292.0	1	41.7
Grant	272	395.5	244	346.4	251	347.3	186	252.9	205	274.4	209	275.4
Grays Harbor	194	284.6	276	404.8	267	395.0	274	406.8	237	352.7	217	316.8
Island	135	199.0	167	242.1	185	265.8	197	279.4	207	289.3	151	208.6
Jefferson	94	384.7	102	406.1	86	337.9	143	557.2	87	335.2	80	306.5
King	3714	223.8	3413	203.2	3664	215.3	4238	246.4	3929	226.2	3351	190.6
Kitsap	416	186.3	519	227.5	346	150.5	395	172.1	373	160.8	374	160.2
Kittitas	113	354.6	86	266.0	95	294.0	85	246.1	98	293.7	113	332.4
Klickitat	97	529.7	111	595.9	160	867.0	101	537.4	135	704.6	113	585.5
Lewis	172	259.5	208	308.8	155	228.2	183	267.0	149	217.2	168	241.7
Lincoln	27	281.3	26	263.1	24	238.1	29	285.9	46	451.7	29	284.3
Mason	88	189.3	78	165.0	98	204.5	149	307.1	182	368.4	122	246.0
Okanogan	278	709.5	281	697.7	377	956.2	496	1,258.0	452	1,142.5	457	1,151.1
Pacific	68	325.8	86	413.2	72	344.0	57	271.7	75	357.4	62	295.2
Pend Oreille	51	426.5	50	423.2	64	540.2	80	686.5	81	690.4	58	491.5
Pierce	1643	249.7	1781	266.6	1869	274.7	1940	280.5	1495	213.3	1457	204.2
San Juan	58	460.6	44	340.9	51	385.2	51	363.8	53	376.5	74	513.9
Skagit	534	556.5	453	463.0	479	479.7	470	460.5	460	446.7	484	464.9
Skamania	34	364.1	35	366.1	32	334.7	29	302.6	33	334.3	30	303.0
Snohomish	1117	207.0	1183	212.4	1168	202.7	1437	242.9	1491	246.0	1477	238.8
Spokane	1148	282.4	1196	292.0	1083	261.9	1138	273.1	1214	290.5	1317	311.8
Stevens	117	320.5	109	289.8	114	299.0	118	304.4	97	242.1	112	277.9
Thurston	443	226.8	439	220.5	384	189.7	353	171.7	410	197.7	392	186.5
Wahkiakum	23	607.8	26	669.6	22	566.3	23	593.5	36	941.4	25	657.9
Walla Walla	198	359.7	165	298.7	169	304.4	184	333.9	171	309.9	184	333.3
Whatcom	579	378.0	684	434.4	703	438.8	777	473.0	782	468.8	815	477.7
Whitman	48	118.3	31	76.0	62	151.0	68	165.1	79	193.9	71	176.2
Yakima	1337	599.0	1340	598.4	1521	682.6	1998	893.6	1904	855.4	1959	872.6
Total	15,166	272.4	15,487	273.4	15,724	273.5	17,516	300.4	16,870	286.2	16,394	274.4

* Excludes detox, transitional housing, private pay & Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Marijuana Per 100,000 in Population



Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

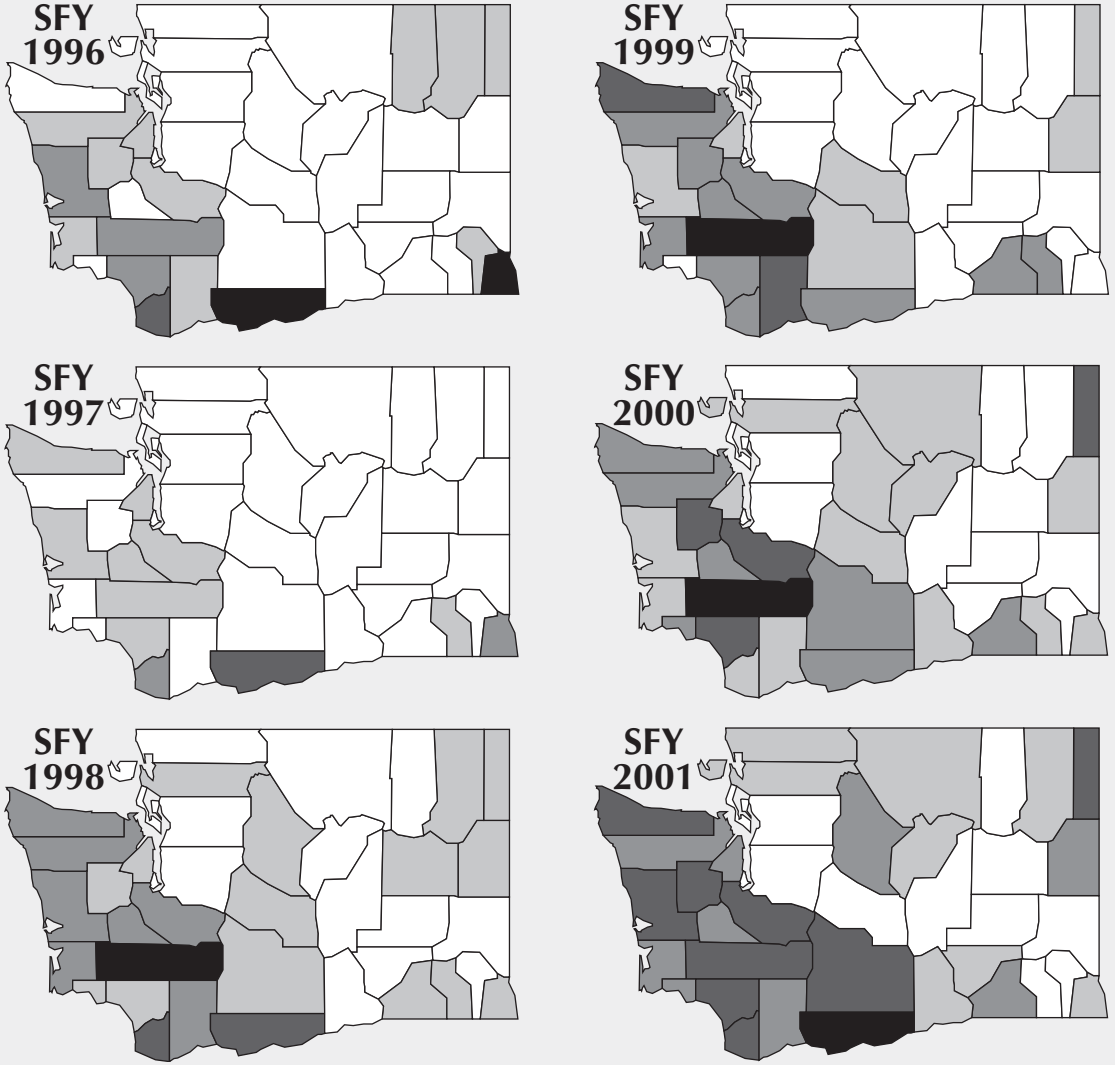
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Adult Treatment Admissions* Primary Drug = Marijuana

County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	6	38.3	4	25.0	2	12.4	1	6.2	2	12.2	9	54.2
Asotin	34	169.6	26	128.2	15	72.2	12	58.2	13	63.3	14	67.6
Benton	69	51.8	58	42.5	66	47.9	93	66.2	86	60.4	121	83.6
Chelan	51	78.6	47	71.3	69	103.9	62	92.7	50	75.1	77	114.8
Clallam	15	24.1	34	54.1	52	82.0	73	113.4	91	141.0	125	192.9
Clark	125	41.1	162	51.1	155	47.3	210	62.2	194	56.2	307	87.1
Columbia	11	230.5	5	110.4	7	156.1	3	70.2	4	98.4	5	122.0
Cowlitz	64	71.1	75	82.7	72	78.6	67	72.3	106	114.0	100	106.5
Douglas	17	55.7	11	35.2	7	21.8	14	43.0	18	55.2	17	51.8
Ferry	10	140.3	13	182.4	7	99.4	16	220.1	9	124.0	9	123.3
Franklin	29	62.6	23	48.7	18	37.7	32	66.2	26	52.7	31	61.5
Garfield	2	92.4	5	222.0	0	0.0	0	0.0	0	0.0	1	41.7
Grant	27	39.3	42	59.6	33	45.7	38	51.7	42	56.2	28	36.9
Grays Harbor	71	104.2	61	89.5	53	78.4	56	83.1	47	69.9	51	74.5
Island	20	29.5	23	33.3	25	35.9	28	39.7	49	68.5	28	38.7
Jefferson	15	61.4	18	71.7	27	106.1	27	105.2	22	84.8	26	99.6
King	430	25.9	388	23.1	492	28.9	644	37.4	741	42.7	761	43.3
Kitsap	78	34.9	121	53.0	90	39.2	105	45.7	92	39.7	129	55.3
Kittitas	8	25.1	16	49.5	23	71.2	18	52.1	27	80.9	16	47.1
Klickitat	17	92.8	21	112.7	39	211.3	27	143.7	30	156.6	35	181.3
Lewis	34	51.3	42	62.4	40	58.9	74	108.0	76	110.8	72	103.6
Lincoln	7	72.9	7	70.8	5	49.6	6	59.1	6	58.9	7	68.6
Mason	28	60.2	20	42.3	15	31.3	26	53.6	46	93.1	45	90.7
Okanogan	32	81.7	19	47.2	24	60.9	25	63.4	45	113.7	51	128.5
Pacific	6	28.7	12	57.7	33	157.7	20	95.3	19	90.5	25	119.0
Pend Oreille	9	75.3	5	42.3	11	92.8	21	180.2	17	144.9	9	76.3
Pierce	267	40.6	331	49.5	424	62.3	546	79.0	578	82.5	591	82.8
San Juan	7	55.6	10	77.5	10	75.5	8	57.1	15	106.6	26	180.6
Skagit	70	72.9	72	73.6	74	74.1	100	98.0	119	115.6	128	123.0
Skamania	6	64.3	11	115.1	8	83.7	11	114.8	12	121.6	12	121.2
Snohomish	103	19.1	165	29.6	200	34.7	258	43.6	383	63.2	387	62.6
Spokane	245	60.3	261	63.7	230	55.6	308	73.9	373	89.2	397	94.0
Stevens	25	68.5	12	31.9	31	81.3	26	67.1	30	74.9	30	74.4
Thurston	96	49.1	121	60.8	75	37.1	92	44.8	135	65.1	138	65.7
Wahkiakum	2	52.9	3	77.3	3	77.2	7	180.6	8	209.2	3	78.9
Walla Walla	40	72.7	27	48.9	36	64.8	41	74.4	60	108.7	72	130.4
Whatcom	86	56.1	80	50.8	99	61.8	123	74.9	116	69.5	177	103.8
Whitman	14	34.5	18	44.1	11	26.8	9	21.8	14	34.4	25	62.0
Yakima	199	89.2	233	104.1	326	146.3	446	199.5	497	223.3	562	250.3
Total	2,375	42.7	2,602	45.9	2,907	50.6	3,673	63.0	4,198	71.2	4,647	77.8

* Excludes Detox, Transitional Housing & Group Care Enhancement, private pay admissions. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Methamphetamine Per 100,000 in Population



Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

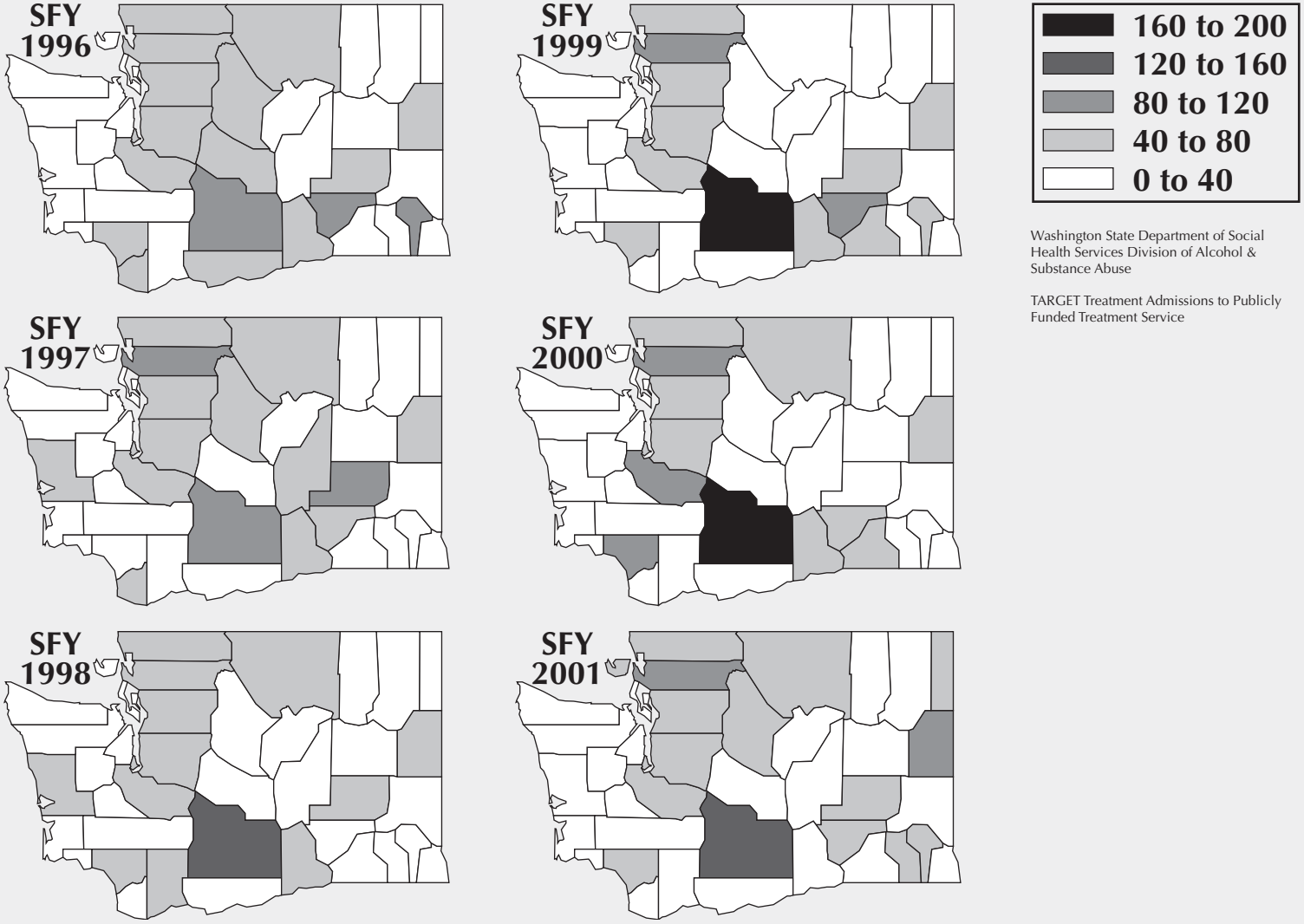
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Adult Treatment Admissions* Primary Drug = Methamphetamine

County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	1	6.3	4	24.9	1	6.2	3	18.3	0	0.0
Asotin	45	224.4	21	103.6	17	81.8	10	48.5	16	77.9	20	96.6
Benton	57	42.8	61	44.7	55	39.9	69	49.1	87	61.1	131	90.5
Chelan	19	29.3	18	27.3	35	52.7	20	29.9	44	66.1	75	111.8
Clallam	30	48.1	48	76.3	72	113.5	100	155.4	91	141.0	105	162.0
Clark	460	151.1	356	112.2	546	166.6	478	141.6	493	142.8	679	192.6
Columbia	2	41.9	4	88.4	3	66.9	5	117.0	3	73.8	2	48.8
Cowlitz	105	116.6	73	80.5	71	77.5	130	140.2	169	181.8	181	192.8
Douglas	10	32.8	4	12.8	13	40.6	13	40.0	22	67.5	22	67.1
Ferry	4	56.1	3	42.1	0	0.0	0	0.0	0	0.0	3	41.1
Franklin	16	34.5	13	27.5	9	18.8	23	47.6	18	36.5	36	71.4
Garfield	2	92.4	0	0.0	0	0.0	1	41.9	0	0.0	0	0.0
Grant	9	13.1	16	22.7	14	19.4	11	15.0	12	16.1	22	29.0
Grays Harbor	78	114.4	59	86.5	86	127.2	56	83.1	59	87.8	105	153.3
Island	5	7.4	3	4.3	16	23.0	13	18.4	20	27.9	34	47.0
Jefferson	21	85.9	7	27.9	31	121.8	38	148.1	32	123.3	32	122.6
King	251	15.1	234	13.9	363	21.3	397	23.1	454	26.1	580	33.0
Kitsap	132	59.1	141	61.8	196	85.3	178	77.5	206	88.8	271	116.1
Kittitas	9	28.2	12	37.1	23	71.2	21	60.8	30	89.9	14	41.2
Klickitat	42	229.4	36	193.3	32	173.4	24	127.7	21	109.6	48	248.7
Lewis	81	122.2	65	96.5	137	201.7	168	245.1	152	221.6	118	169.8
Lincoln	0	0.0	2	20.2	6	59.5	1	9.9	3	29.5	2	19.6
Mason	24	51.6	20	42.3	31	64.7	55	113.4	75	151.8	88	177.4
Okanogan	7	17.9	2	5.0	11	27.9	12	30.4	20	50.6	24	60.5
Pacific	12	57.5	4	19.2	22	105.1	22	104.9	11	52.4	26	123.8
Pend Oreille	7	58.5	1	8.5	10	84.4	8	68.6	22	187.5	19	161.0
Pierce	488	74.2	472	70.6	798	117.3	969	140.1	1108	158.1	1272	178.3
San Juan	0	0.0	4	31.0	4	30.2	4	28.5	8	56.8	8	55.6
Skagit	15	15.6	26	26.6	64	64.1	41	40.2	72	69.9	99	95.1
Skamania	9	96.4	4	41.8	13	136.0	16	166.9	8	81.0	11	111.1
Snohomish	70	13.0	106	19.0	181	31.4	212	35.8	244	40.3	279	45.1
Spokane	195	48.0	170	41.5	227	54.9	294	70.6	372	89.0	522	123.6
Stevens	19	52.1	14	37.2	21	55.1	19	49.0	19	47.4	23	57.1
Thurston	80	40.9	110	55.3	245	121.1	209	101.7	222	107.1	265	126.1
Wahkiakum	1	26.4	0	0.0	3	77.2	1	25.8	5	130.8	5	131.6
Walla Walla	27	49.0	24	43.4	55	99.1	60	108.9	68	123.2	59	106.9
Whatcom	14	9.1	24	15.2	30	18.7	50	30.4	74	44.4	92	53.9
Whitman	2	4.9	5	12.3	8	19.5	7	17.0	6	14.7	10	24.8
Yakima	91	40.8	55	24.6	165	74.0	219	97.9	241	108.3	418	186.2
Total	2,439	43.8	2,218	39.2	3,617	62.9	3,955	67.8	4,510	76.5	5,700	95.4

* Excludes Detox, Transitional Housing & Group Care Enhancement, private pay admissions. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Cocaine Per 100,000 in Population



Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

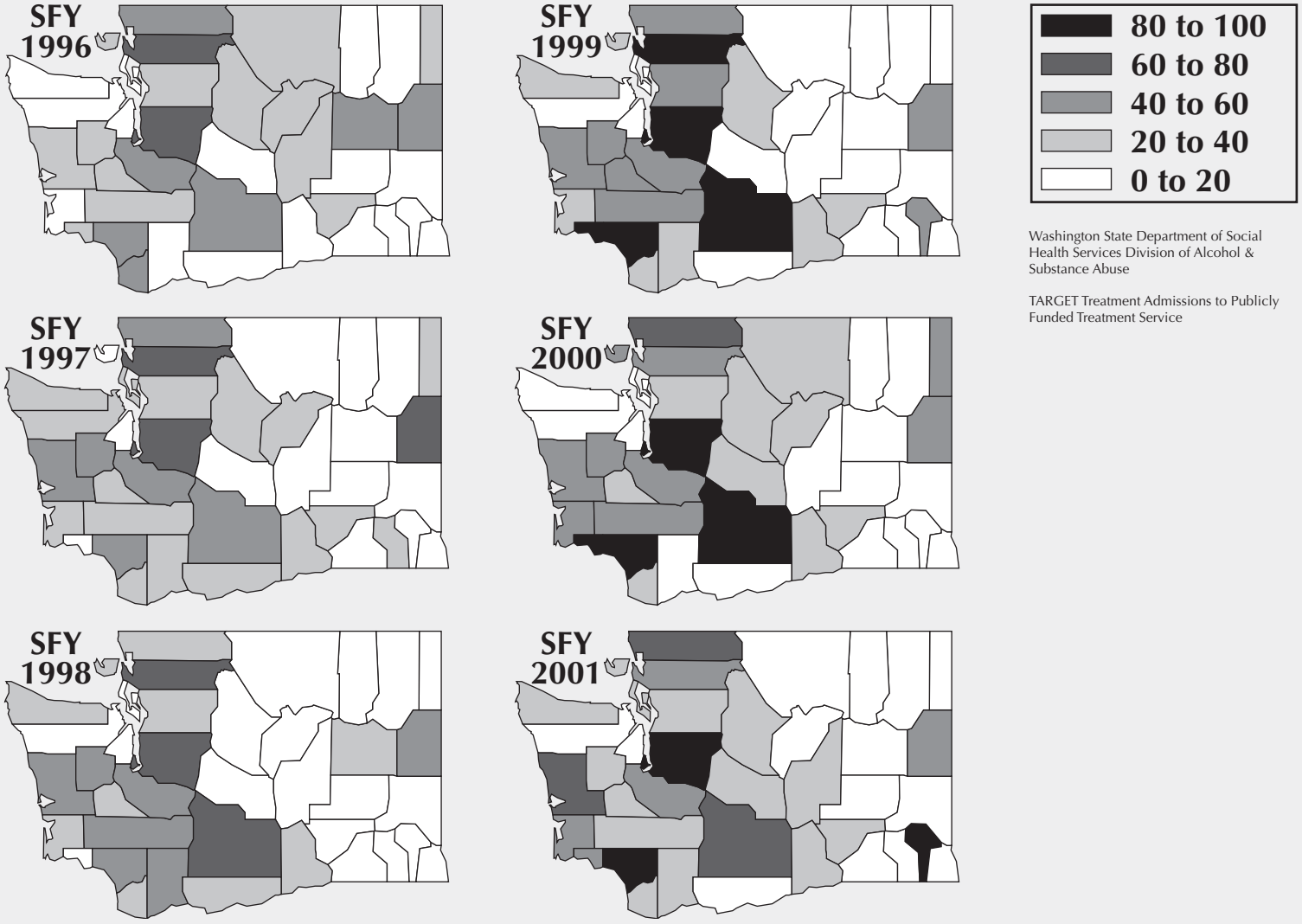
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Adult Treatment Admissions* Primary Drug = Cocaine

County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	9	57.4	18	112.6	10	62.1	8	49.4	6	36.5	8	48.2
Asotin	6	29.9	4	19.7	1	4.8	3	14.6	2	9.7	1	4.8
Benton	60	45.0	55	40.3	37	26.8	77	54.8	57	40.0	53	36.6
Chelan	44	67.8	35	53.1	29	43.7	18	26.9	21	31.5	27	40.2
Clallam	3	4.8	16	25.4	10	15.8	20	31.1	14	21.7	16	24.7
Clark	135	44.4	166	52.3	128	39.0	117	34.7	84	24.3	109	30.9
Columbia	0	0.0	0	0.0	1	22.3	0	0.0	1	24.6	2	48.8
Cowlitz	52	57.7	70	77.2	55	60.0	46	49.6	83	89.3	71	75.6
Douglas	6	19.7	7	22.4	5	15.6	4	12.3	12	36.8	7	21.3
Ferry	2	28.1	0	0.0	1	14.2	1	13.8	1	13.8	0	0.0
Franklin	38	82.0	31	65.7	15	31.4	43	89.0	31	62.8	33	65.5
Garfield	2	92.4	0	0.0	0	0.0	1	41.9	0	0.0	1	41.7
Grant	25	36.4	38	54.0	26	36.0	21	28.6	28	37.5	20	26.4
Grays Harbor	17	24.9	49	71.9	39	57.7	25	37.1	16	23.8	20	29.2
Island	12	17.7	11	15.9	12	17.2	15	21.3	13	18.2	10	13.8
Jefferson	4	16.4	4	15.9	3	11.8	2	7.8	1	3.9	3	11.5
King	1231	74.2	1167	69.5	1138	66.9	1372	79.8	1386	79.8	1223	69.6
Kitsap	62	27.8	89	39.0	44	19.1	47	20.5	53	22.8	53	22.7
Kittitas	14	43.9	8	24.7	3	9.3	2	5.8	7	21.0	4	11.8
Klickitat	10	54.6	5	26.8	6	32.5	2	10.6	4	20.9	3	15.5
Lewis	4	6.0	5	7.4	8	11.8	6	8.8	10	14.6	3	4.3
Lincoln	3	31.3	1	10.1	1	9.9	3	29.6	1	9.8	1	9.8
Mason	8	17.2	3	6.3	11	23.0	13	26.8	11	22.3	14	28.2
Okanogan	18	45.9	19	47.2	21	53.3	10	25.4	19	48.0	23	57.9
Pacific	4	19.2	6	28.8	6	28.7	5	23.8	5	23.8	4	19.0
Pend Oreille	0	0.0	2	16.9	3	25.3	1	8.6	2	17.0	6	50.8
Pierce	463	70.4	493	73.8	521	76.6	641	92.7	577	82.3	514	72.0
San Juan	1	7.9	4	31.0		0.0		0.0	3	21.3	9	62.5
Skagit	72	75.0	97	99.1	69	69.1	111	108.7	119	115.6	98	94.1
Skamania	3	32.1	3	31.4	4	41.8	1	10.4	1	10.1	2	20.2
Snohomish	240	44.5	312	56.0	350	60.7	377	63.7	355	58.6	351	56.7
Spokane	246	60.5	277	67.6	242	58.5	296	71.0	301	72.0	348	82.4
Stevens	8	21.9	10	26.6	2	5.2	6	15.5	9	22.5	4	9.9
Thurston	70	35.8	54	27.1	33	16.3	53	25.8	56	27.0	45	21.4
Wahkiakum	0	0.0	0	0.0	0	0.0	0	0.0	1	26.2	0	0.0
Walla Walla	12	21.8	10	18.1	12	21.6	25	45.4	23	41.7	16	29.0
Whatcom	64	41.8	74	47.0	87	54.3	81	49.3	99	59.3	105	61.5
Whitman	4	9.9	1	2.5	1	2.4	1	2.4	2	4.9	9	22.3
Yakima	217	97.2	268	119.7	297	133.3	400	178.9	365	164.0	359	159.9
Total	3,169	56.9	3,412	60.2	3,231	56.2	3,854	66.1	3,779	64.1	3,575	59.8

* Excludes Detox, Transitional Housing & Group Care Enhancement, private pay admissions. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Heroin Per 100,000 in Population



Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

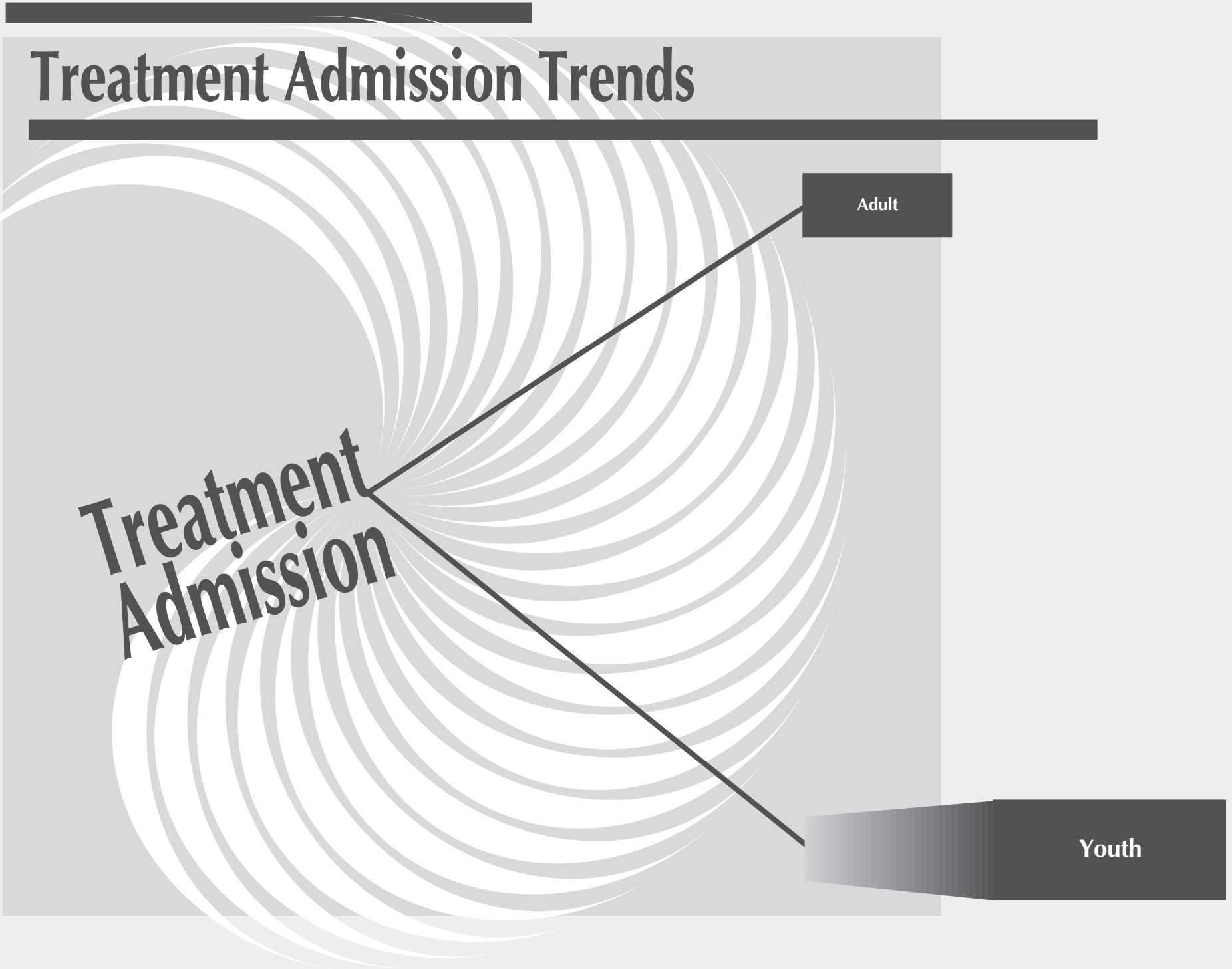
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Adult Treatment Admissions* Primary Drug = Heroin

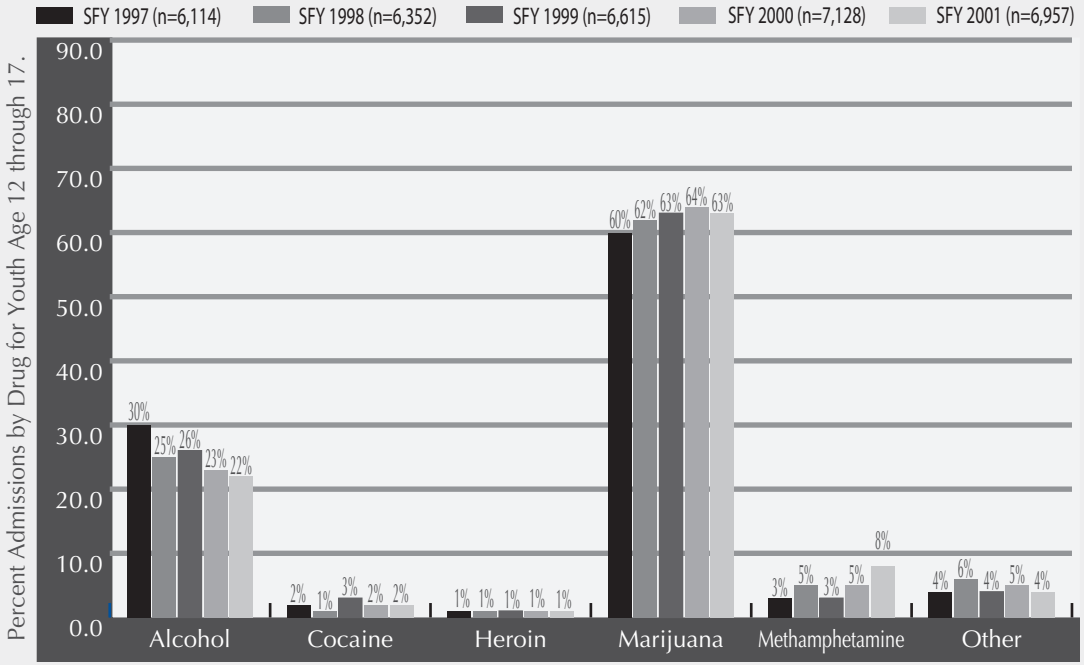
County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	1	6.4	0	0.0	0	0.0	2	12.4	1	6.1	2	12.0
Asotin	1	5.0	4	19.7	4	19.2	2	9.7	3	14.6	4	19.3
Benton	18	13.5	39	28.6	47	34.1	55	39.2	33	23.2	34	23.5
Chelan	16	24.7	21	31.8	11	16.6	15	22.4	23	34.5	25	37.3
Clallam	4	6.4	15	23.9	19	29.9	20	31.1	12	18.6	14	21.6
Clark	135	44.4	89	28.0	130	39.7	118	35.0	113	32.7	125	35.5
Columbia	1	21.0	1	22.1	0	0.0	0	0.0	0	0.0	0	0.0
Cowlitz	37	41.1	40	44.1	53	57.9	86	92.8	158	170.0	93	99.0
Douglas	10	32.8	7	22.4	7	21.8	3	9.2	8	24.5	5	15.2
Ferry	0	0.0	0	0.0	1	14.2	0	0.0	1	13.8	0	0.0
Franklin	11	23.7	11	23.3	9	18.8	16	33.1	16	32.4	16	31.7
Garfield	0	0.0	0	0.0	0	0.0	1	41.9	0	0.0	2	83.3
Grant	15	21.8	12	17.0	11	15.2	10	13.6	8	10.7	22	29.0
Grays Harbor	30	44.0	29	42.5	29	42.9	33	49.0	39	58.0	45	65.7
Island	4	5.9	19	27.5	8	11.5	11	15.6	8	11.2	16	22.1
Jefferson	3	12.3	6	23.9	2	7.9	5	19.5	2	7.7	4	15.3
King	1259	75.9	1298	77.3	1322	77.7	1382	80.3	1807	104.0	1406	80.0
Kitsap	31	13.9	33	14.5	35	15.2	34	14.8	28	12.1	27	11.6
Kittitas	5	15.7	3	9.3	3	9.3	3	8.7	9	27.0	8	23.5
Klickitat	2	10.9	4	21.5	4	21.7	2	10.6	2	10.4	2	10.4
Lewis	16	24.1	18	26.7	34	50.1	38	55.4	30	43.7	17	24.5
Lincoln	4	41.7		0.0	3	29.8	1	9.9	1	9.8	0	0.0
Mason	12	25.8	21	44.4	24	50.1	25	51.5	27	54.7	19	38.3
Okanogan	8	20.4	5	12.4	5	12.7	1	2.5	8	20.2	3	7.6
Pacific	3	14.4	7	33.6	5	23.9	8	38.1	11	52.4	11	52.4
Pend Oreille	4	33.4	3	25.4	1	8.4	1	8.6	5	42.6	1	8.5
Pierce	350	53.2	376	56.3	405	59.5	396	57.3	342	48.8	414	58.0
San Juan	4	31.8	1	7.7	4	30.2	4	28.5	7	49.7	5	34.7
Skagit	64	66.7	60	61.3	68	68.1	92	90.1	60	58.3	55	52.8
Skamania	0	0.0	2	20.9	5	52.3	2	20.9	0	0.0	3	30.3
Snohomish	155	28.7	186	33.4	159	27.6	272	46.0	230	38.0	195	31.5
Spokane	205	50.4	246	60.1	207	50.1	201	48.2	246	58.9	223	52.8
Stevens	4	11.0	6	16.0	2	5.2	3	7.7	4	10.0	3	7.4
Thurston	60	30.7	76	38.2	76	37.6	108	52.5	71	34.2	78	37.1
Wahkiakum	1	26.4	0	0.0	0	0.0	5	129.0	6	156.9	2	52.6
Walla Walla	9	16.3	6	10.9	4	7.2	9	16.3	9	16.3	6	10.9
Whatcom	70	45.7	80	50.8	74	46.2	71	43.2	114	68.3	123	72.1
Whitman	2	4.9	0	0.0	0	0.0	2	4.9	0	0.0	0	0.0
Yakima	117	52.4	128	57.2	175	78.5	195	87.2	222	99.7	164	73.1
Total	2,671	48.0	2,852	50.4	2,946	51.2	3,232	55.4	3,664	62.2	3,172	53.1

* Excludes Detox, Transitional Housing & Group Care Enhancement, private pay admissions. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Admission Trends



Marijuana is the Most Frequently Cited Primary Drug of Abuse in Youth Admissions to DASA-Funded Treatment.*



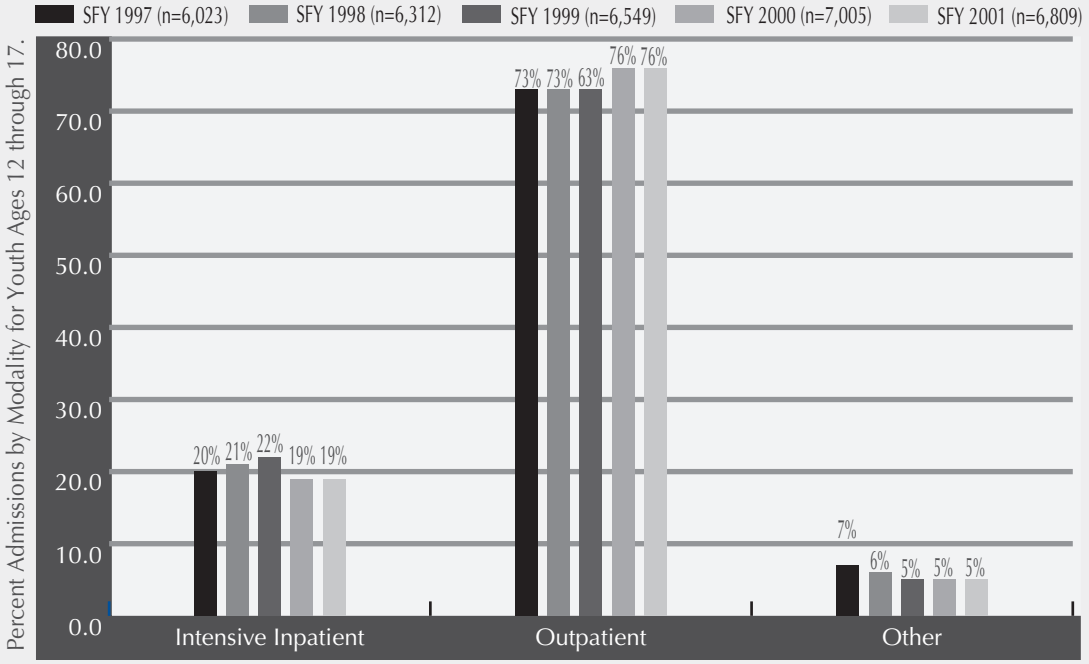
Treatment and Assessment Report Generation Tool (TARGET), Department of Social and Health Services, Division of Alcohol and Substance Abuse.

This graph indicates that in SFY 2001, marijuana was the primary drug of abuse for the majority of youth admissions to DASA-funded treatment services. Overall youth admissions increased from 6,114 in SFY 1997 to 6,957 in SFY 2001, representing a 13.8% increase. Treatment admissions for methamphetamine have more than tripled, from 169 in SFY 1997 to 551 in SFR 2001.

Note: These may include some multiple admissions for a single individual over the course of year.

**excludes detoxification and transitional housing*

The Majority of Youth Admissions to DASA-Funded Chemical Dependency Treatment are for Outpatient Services.

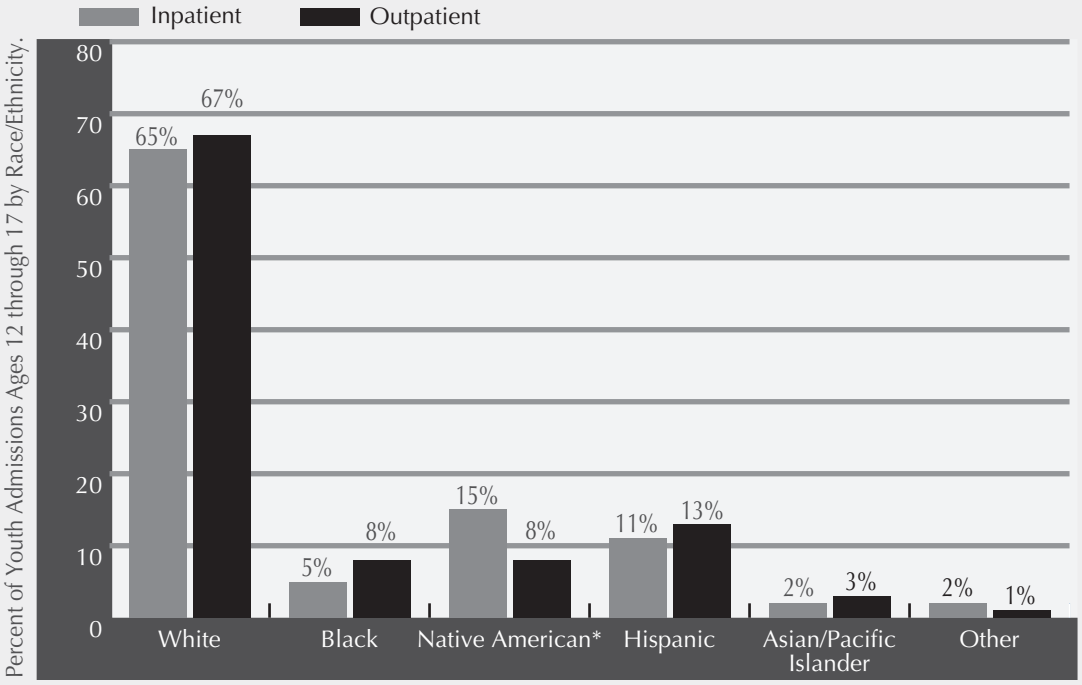


Treatment and Assessment Report Generation Tool (TARGET), Department of Social and Health Services, Division of Alcohol and Substance Abuse.

Three-quarters of youth admissions to DASA-funded chemical dependency treatment services are for outpatient treatment (including intensive outpatient).

Note: These data may include multiple admissions for the same individual over the course of the year. "Other" includes group care enhancements, recovery house, long-term residential, methadone, and treatment services for those with co-occurring disorders.

In SFY 2001, Racial and Ethnic Minorities Comprised Approximately One-Third of Youth Admissions to DASA-Funded Chemical Dependency Treatment Services.

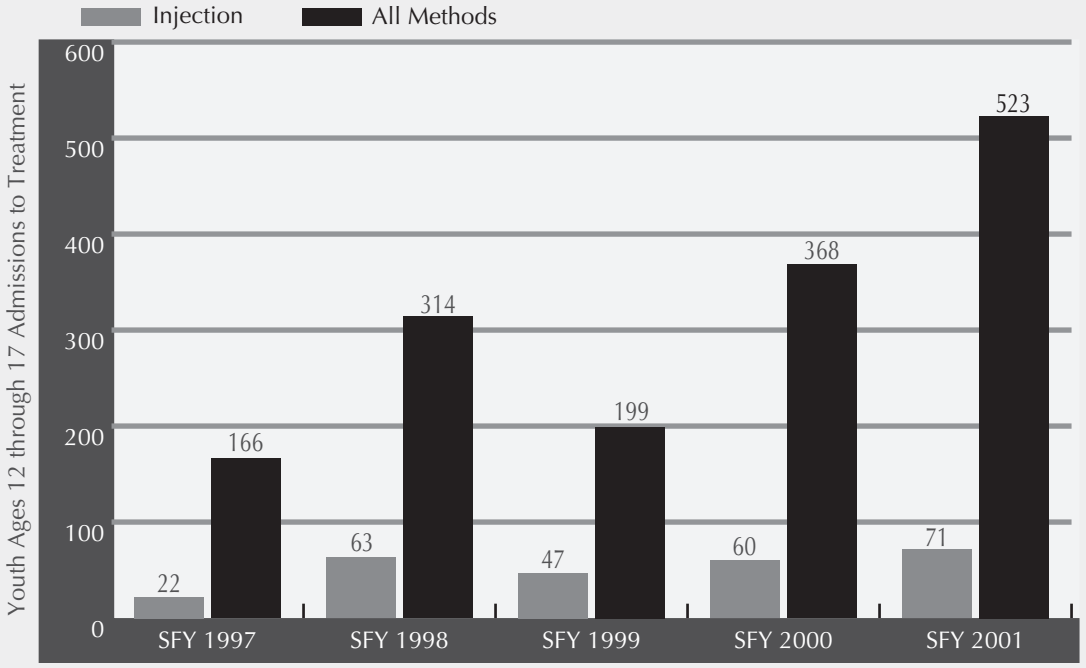


Treatment Assessment Report Generation Tool (TARGET), Department of Social and Health Services, Division of Alcohol and Substance Abuse.

This graph indicates that racial/ethnic minorities comprised between 33-35% of youth admissions to DASA-funded chemical dependency treatment services. Percentages of youth from different minority groups receiving DASA-funded treatment vary across modalities.

**Includes Eskimo/Alaskan Native/Aleut*

DASA-Funded Youth Treatment Admissions for Methamphetamine Use Have More than Tripled in the Past Five Years.

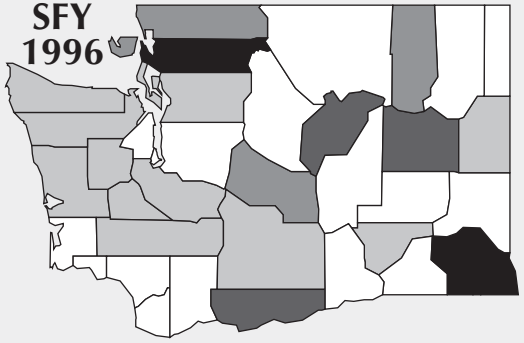


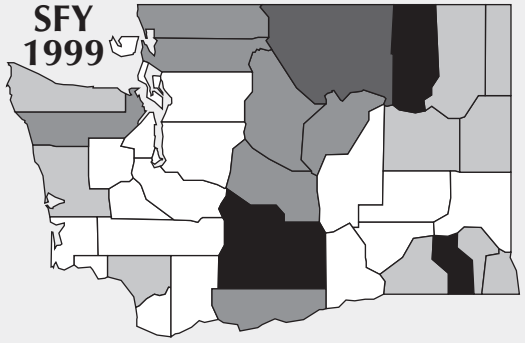
Treatment and Assessment Report Generation Tool (TARGET), Washington State Department of Social and Health Services.

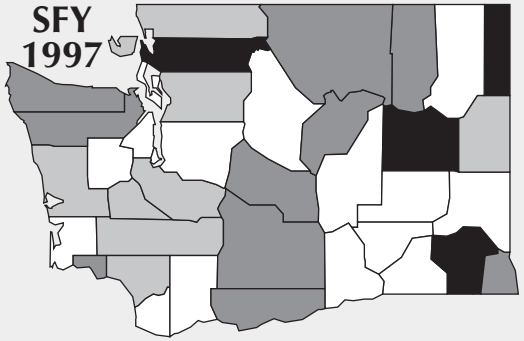
This graph indicates that youth admissions to DASA-funded treatment for methamphetamine use have more than tripled over the past five years. Youth are far less likely to inject methamphetamine than are adults.

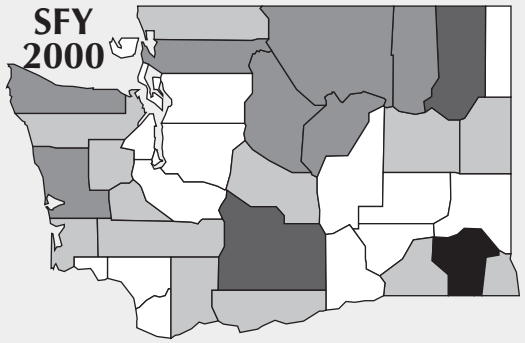
Note: Excludes detoxification and transitional housing, private-pay and Department of Corrections admissions. Includes total unduplicated admissions within counties.

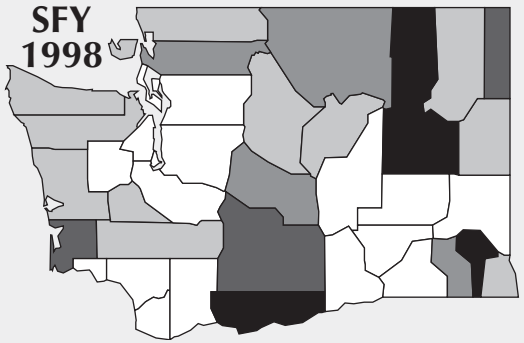
Washington State Youth Treatment Admissions for Alcohol Per 100,000 in Population

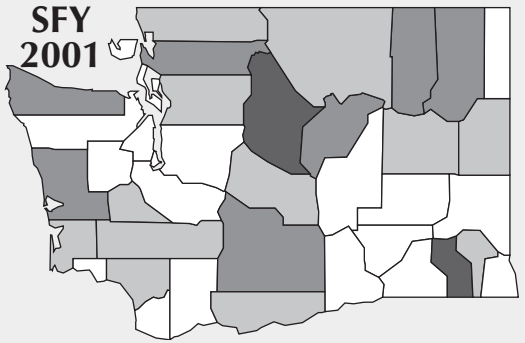


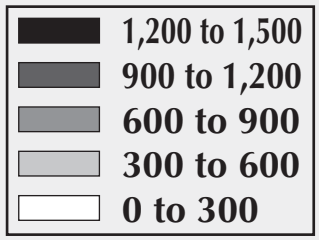












Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

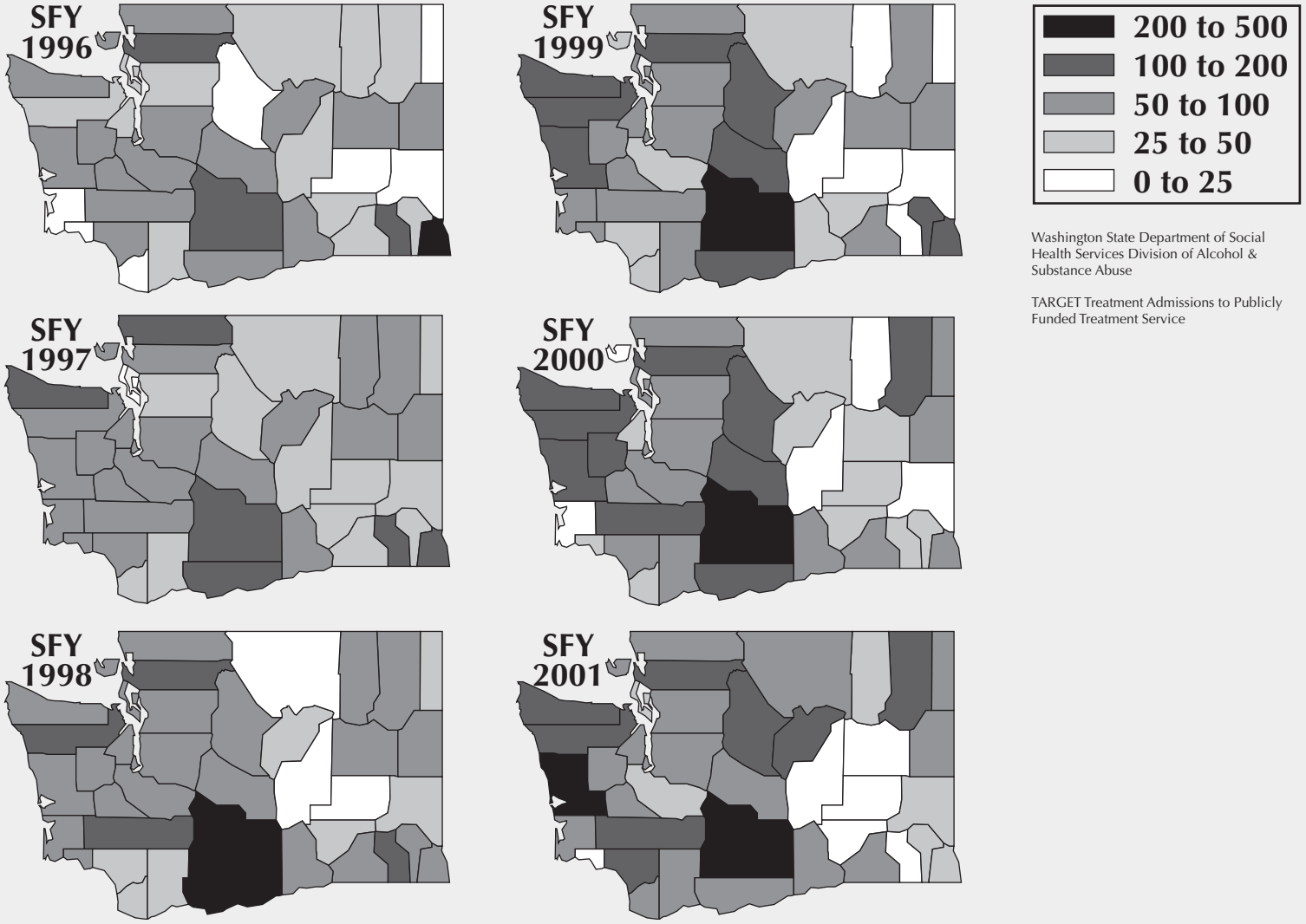
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Youth Treatment Admissions * Primary Drug = Alcohol

County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	2	12.8	3	18.8	3	18.6	1	6.2	3	18.3	2	12.0
Asotin	33	164.6	12	59.2	9	43.3	10	48.5	6	29.2	2	9.7
Benton	19	14.3	27	19.8	23	16.7	16	11.4	27	19.0	14	9.7
Chelan	8	12.3	12	18.2	23	34.6	48	71.7	45	67.6	65	96.9
Clallam	28	44.9	42	66.8	31	48.9	32	49.7	45	69.7	33	50.9
Clark	30	9.9	43	13.6	44	13.4	46	13.6	40	11.6	35	9.9
Columbia	15	314.3	7	154.6	3	66.9	6	140.4	5	123.0	4	97.6
Cowlitz	21	23.3	31	34.2	16	17.5	24	25.9	23	24.7	25	26.6
Douglas	30	98.3	19	60.8	9	28.1	22	67.6	18	55.2	18	54.9
Ferry	5	70.1	4	56.1	13	184.6	9	123.8	4	55.1	5	68.5
Franklin	13	28.0	7	14.8	11	23.0	6	12.4	12	24.3	7	13.9
Garfield	8	369.7	5	222.0	4	175.5	1	41.9	5	208.6	1	41.7
Grant	6	8.7	16	22.7	10	13.8	11	15.0	8	10.7	5	6.6
Grays Harbor	23	33.7	23	33.7	19	28.1	33	49.0	45	67.0	47	68.6
Island	25	36.8	14	20.3	8	11.5	7	9.9	15	21.0	14	19.3
Jefferson	8	32.7	13	51.8	8	31.4	17	66.2	9	34.7	2	7.7
King	339	20.4	359	21.4	357	21.0	373	21.7	342	19.7	294	16.7
Kitsap	50	22.4	49	21.5	51	22.2	43	18.7	12	5.2	23	9.9
Kittitas	19	59.6	17	52.6	24	74.3	21	60.8	15	45.0	15	44.1
Klickitat	14	76.5	12	64.4	20	108.4	12	63.9	6	31.3	7	36.3
Lewis	32	48.3	26	38.6	31	45.6	17	24.8	32	46.6	25	36.0
Lincoln	9	93.8	19	192.2	14	138.9	4	39.4	5	49.1	5	49.0
Mason	15	32.3	9	19.0	8	16.7	11	22.7	15	30.4	3	6.0
Okanogan	4	10.2	26	64.6	26	65.9	39	98.9	28	70.8	14	35.3
Pacific	3	14.4	5	24.0	17	81.2	9	42.9	6	28.6	13	61.9
Pend Oreille	1	8.4	12	101.6	11	92.8		0.0	1	8.5	3	25.4
Pierce	325	49.4	192	28.7	132	19.4	129	18.7	125	17.8	100	14.0
San Juan	8	63.5	5	38.7	4	30.2	1	7.1	2	14.2	2	13.9
Skagit	143	149.0	136	139.0	51	51.1	76	74.5	74	71.9	52	50.0
Skamania	1	10.7	2	20.9	1	10.5	1	10.4	3	30.4	0	0.0
Snohomish	165	30.6	149	26.7	109	18.9	96	16.2	109	18.0	159	25.7
Spokane	117	28.8	154	37.6	108	26.1	127	30.5	119	28.5	141	33.4
Stevens	7	19.2	4	10.6	13	34.1	13	33.5	38	94.8	26	64.5
Thurston	94	48.1	71	35.7	83	41.0	51	24.8	52	25.1	81	38.5
Wahkiakum	0	0.0	2	51.5	0	0.0	0	0.0	0	0.0	0	0.0
Walla Walla	9	16.3	12	21.7	7	12.6	15	27.2	15	27.2	11	19.9
Whatcom	105	68.6	73	46.4	69	43.1	92	56.0	82	49.2	61	35.8
Whitman	4	9.9	3	7.4	7	17.0	7	17.0	2	4.9	3	7.4
Yakima	107	47.9	132	59.0	183	82.1	223	99.7	185	83.1	156	69.5
Total	1,845	33.1	1,747	30.8	1,560	27.1	1,649	28.3	1,578	26.8	1,473	24.7

* Excludes Detox, Transitional Housing & Group Care Enhancement, private pay admissions. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Marijuana Per 100,000 in Population



Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

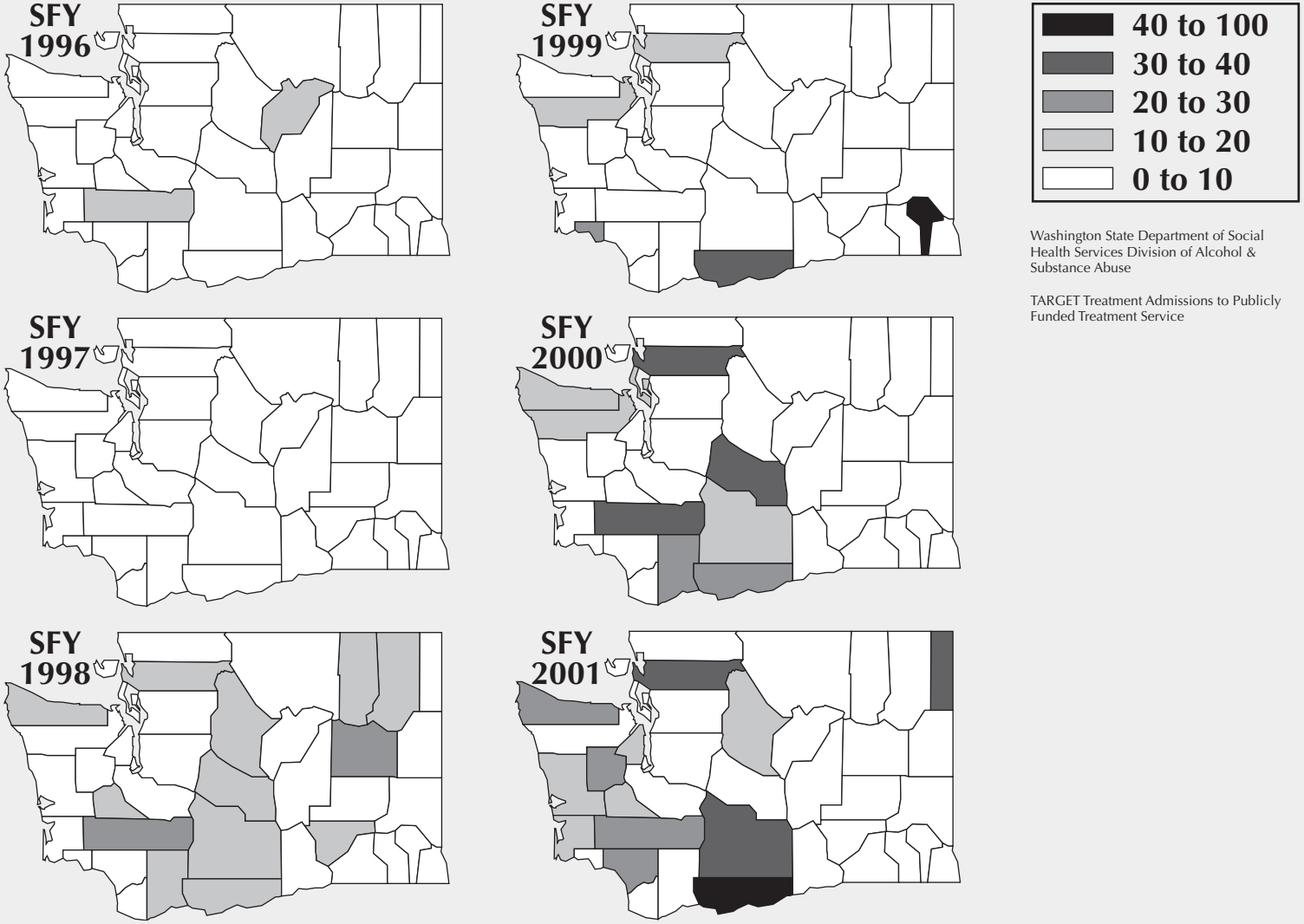
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Youth Treatment Admissions * Primary Drug = Marijuana

County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	1	6.4	7	43.8	2	12.4	2	12.4	7	42.6	4	24.1
Asotin	62	309.2	23	113.5	14	67.4	21	101.9	18	87.6	6	29.0
Benton	77	57.8	79	57.9	85	61.6	50	35.6	79	55.4	83	57.3
Chelan	11	17.0	24	36.4	35	52.7	68	101.6	72	108.1	70	104.3
Clallam	54	86.6	86	136.7	41	64.6	81	125.8	112	173.6	83	128.1
Clark	93	30.6	99	31.2	132	40.3	162	48.0	157	45.5	193	54.7
Columbia	6	125.7	5	110.4	5	111.5	1	23.4	2	49.2	1	24.4
Cowlitz	51	56.6	58	63.9	41	44.8	38	41.0	80	86.1	85	90.5
Douglas	25	81.9	23	73.6	12	37.4	21	64.6	11	33.7	30	91.5
Ferry	2	28.1	5	70.2	7	99.4	1	13.8	1	13.8	3	41.1
Franklin	13	28.0	20	42.4	17	35.6	15	31.1	20	40.5	11	21.8
Garfield	3	138.6	1	44.4	2	87.8	3	125.6	1	41.7	1	41.7
Grant	20	29.1	25	35.5	16	22.1	14	19.0	15	20.1	18	23.7
Grays Harbor	43	63.1	39	57.2	54	79.9	129	191.5	97	144.4	143	208.8
Island	29	42.7	13	18.8	52	74.7	44	62.4	45	62.9	31	42.8
Jefferson	12	49.1	17	67.7	35	137.5	37	144.2	39	150.3	27	103.4
King	880	53.0	868	51.7	972	57.1	1012	58.8	1196	68.9	1000	56.9
Kitsap	85	38.1	135	59.2	157	68.3	120	52.3	82	35.3	117	50.1
Kittitas	18	56.5	24	74.2	29	89.8	36	104.2	42	125.9	19	55.9
Klickitat	14	76.5	24	128.8	38	205.9	22	117.1	25	130.5	16	82.9
Lewis	40	60.3	59	87.6	68	100.1	50	72.9	90	131.2	103	148.2
Lincoln	9	93.8	10	101.2	9	89.3	8	78.9	5	49.1	2	19.6
Mason	35	75.3	31	65.6	31	64.7	32	66.0	50	101.2	44	88.7
Okanogan	17	43.4	16	39.7	8	20.3	15	38.0	19	48.0	28	70.5
Pacific	5	24.0	16	76.9	20	95.5	16	76.3	4	19.1	19	90.5
Pend Oreille	2	16.7	5	42.3	5	42.2	0	0.0	7	59.7	7	59.3
Pierce	385	58.5	378	56.6	420	61.7	306	44.2	376	53.7	303	42.5
San Juan	12	95.3	8	62.0	10	75.5	6	42.8	3	21.3	9	62.5
Skagit	106	110.5	142	145.1	113	113.2	120	117.6	153	148.6	138	132.6
Skamania	3	32.1	3	31.4	4	41.8	6	62.6	7	70.9	6	60.6
Snohomish	194	36.0	268	48.1	293	50.9	300	50.7	387	63.9	343	55.4
Spokane	256	63.0	369	90.1	295	71.3	365	87.6	362	86.6	379	89.7
Stevens	12	32.9	31	82.4	22	57.7	35	90.3	45	112.3	59	146.4
Thurston	125	64.0	136	68.3	181	89.4	181	88.1	161	77.6	195	92.8
Wahkiakum	0	0.0	3	77.3	2	51.5	2	51.6	1	26.2	0	0.0
Walla Walla	14	25.4	21	38.0	29	52.2	32	58.1	35	63.4	42	76.1
Whatcom	122	79.6	124	78.8	125	78.0	132	80.3	153	91.7	137	80.3
Whitman	9	22.2	12	29.4	11	26.8	9	21.8	3	7.4	12	29.8
Yakima	293	131.3	394	176.0	447	200.6	568	254.0	525	235.9	475	211.6
Total	3,138	56.4	3,601	63.6	3,839	66.8	4,060	69.6	4,487	76.1	4,242	71.0

* Excludes Detox, Transitional Housing & Group Care Enhancement, private pay admissions. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Methamphetamine Per 100,000 in Population



Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

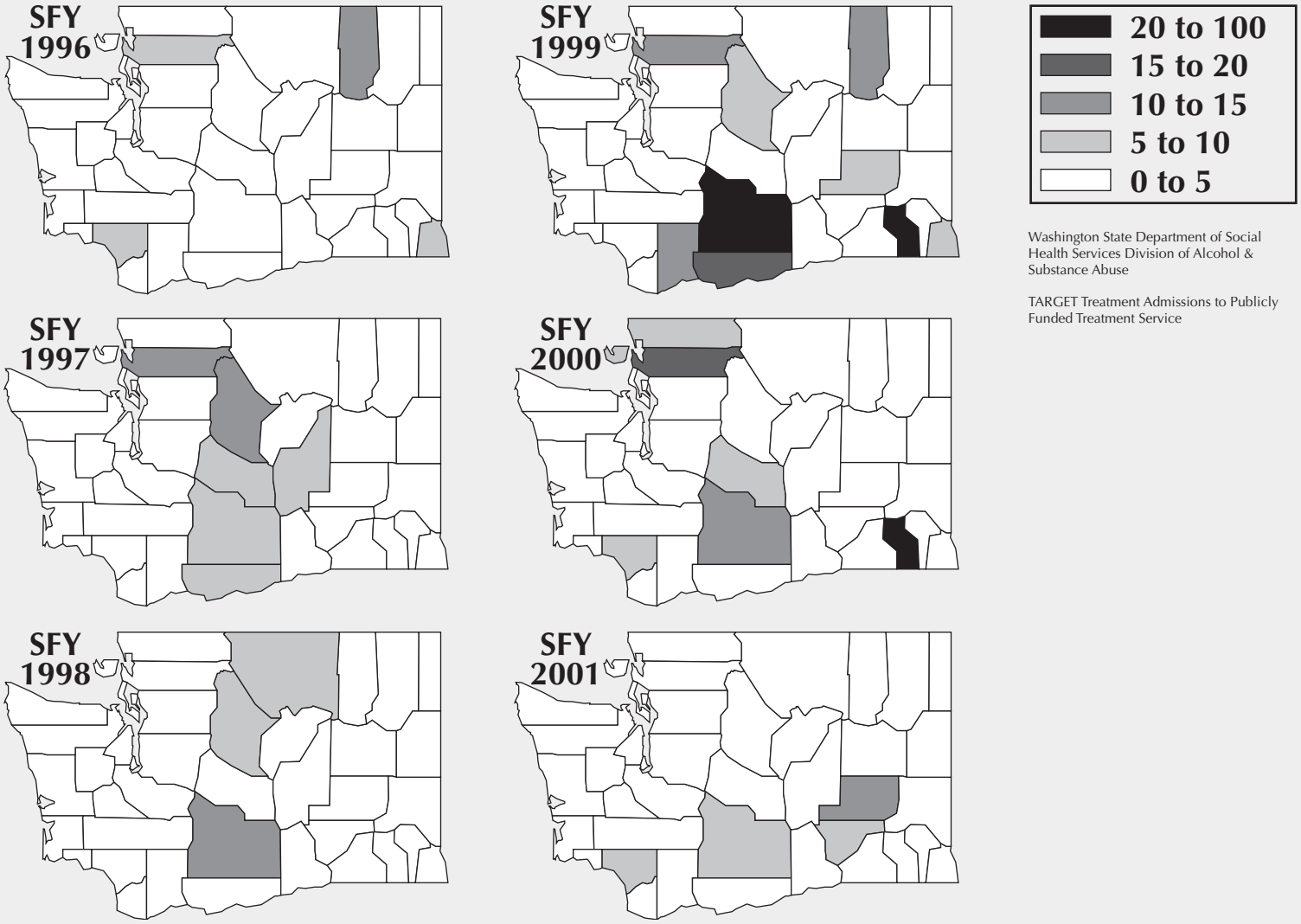
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Youth Treatment Admissions* Primary Drug = Methamphetamine

County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	1	6.3	0	0.0	0	0.0	0	0.0	0	0.0
Asotin	0	0.0	1	4.9	0	0.0	1	4.9	1	4.9	0	0.0
Benton	3	2.3	8	5.9	8	5.8	3	2.1	1	0.7	12	8.3
Chelan	4	6.2	1	1.5	9	13.6	2	3.0	4	6.0	11	16.4
Clallam	3	4.8	5	8.0	7	11.0	4	6.2	10	15.5	17	26.2
Clark	10	3.3	6	1.9	23	7.0	21	6.2	28	8.1	31	8.8
Columbia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cowlitz	5	5.6	3	3.3	6	6.5	3	3.2	7	7.5	24	25.6
Douglas	4	13.1	1	3.2	2	6.2	1	3.1	0	0.0	2	6.1
Ferry	0	0.0	0	0.0	1	14.2	0	0.0	0	0.0	0	0.0
Franklin	2	4.3	0	0.0	5	10.5	0	0.0	2	4.1	2	4.0
Garfield	0	0.0	0	0.0	0	0.0	1	41.9	0	0.0	0	0.0
Grant	2	2.9	0	0.0	3	4.2	0	0.0	0	0.0	1	1.3
Grays Harbor	6	8.8	3	4.4	5	7.4	3	4.5	6	8.9	10	14.6
Island	3	4.4	1	1.4	6	8.6	4	5.7	10	14.0	3	4.1
Jefferson	1	4.1	0	0.0	0	0.0	3	11.7	3	11.6	1	3.8
King	31	1.9	30	1.8	29	1.7	25	1.5	45	2.6	50	2.8
Kitsap	10	4.5	11	4.8	10	4.4	7	3.0	23	9.9	31	13.3
Kittitas	3	9.4	1	3.1	4	12.4	3	8.7	10	30.0	3	8.8
Klickitat	0	0.0	0	0.0	2	10.8	6	31.9	4	20.9	11	57.0
Lewis	11	16.6	5	7.4	15	22.1	0	0.0	24	35.0	17	24.5
Lincoln	0	0.0	0	0.0	3	29.8	1	9.9	1	9.8	0	0.0
Mason	2	4.3	0	0.0	2	4.2	1	2.1	4	8.1	11	22.2
Okanogan	0	0.0	0	0.0	2	5.1	0	0.0	0	0.0	2	5.0
Pacific	0	0.0	0	0.0	0	0.0	1	4.8	2	9.5	3	14.3
Pend Oreille	0	0.0	0	0.0	1	8.4	0	0.0	0	0.0	4	33.9
Pierce	16	2.4	19	2.8	28	4.1	26	3.8	44	6.3	47	6.6
San Juan	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	6.9
Skagit	9	9.4	6	6.1	18	18.0	17	16.7	31	30.1	41	39.4
Skamania	0	0.0	0	0.0	1	10.5	0	0.0	1	10.1	0	0.0
Snohomish	16	3.0	19	3.4	27	4.7	18	3.0	22	3.6	27	4.4
Spokane	27	6.6	18	4.4	29	7.0	9	2.2	31	7.4	32	7.6
Stevens	2	5.5	0	0.0	4	10.5	0	0.0	1	2.5	3	7.4
Thurston	11	5.6	13	6.5	28	13.8	15	7.3	10	4.8	36	17.1
Wahkiakum	0	0.0	0	0.0	0	0.0	1	25.8	0	0.0	0	0.0
Walla Walla	0	0.0	2	3.6	2	3.6	3	5.4	1	1.8	3	5.4
Whatcom	3	2.0	0	0.0	5	3.1	6	3.7	12	7.2	13	7.6
Whitman	2	4.9	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5
Yakima	14	6.3	12	5.4	29	13.0	14	6.3	30	13.5	73	32.5
Total	200	3.6	166	2.9	314	5.5	199	3.4	368	6.2	523	8.8

* Excludes Detox, Transitional Housing & Group Care Enhancement, private pay admissions. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Cocaine Per 100,000 in Population



Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

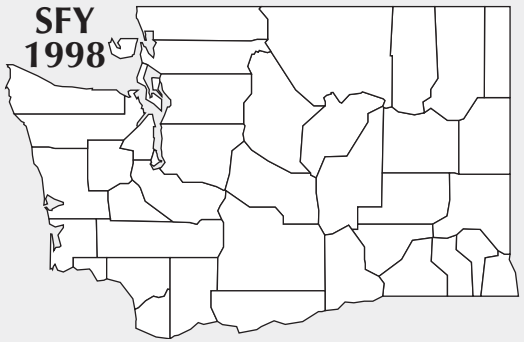
TARGET Treatment Admissions to Publicly Funded Treatment Service

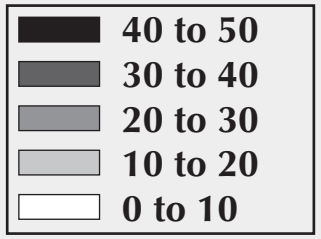
Washington State Youth Treatment Admissions* Primary Drug = Cocaine

County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	0	0.0	0	0.0	1	6.2	0	0.0	2	12.0
Asotin	1	5.0	0	0.0	0	0.0	2	9.7	0	0.0	0	0.0
Benton	1	0.8	1	0.7	1	0.7	1	0.7	2	1.4	4	2.8
Chelan	1	1.5	9	13.6	5	7.5	4	6.0	0	0.0	3	4.5
Clallam	0	0.0	1	1.6	1	1.6	0	0.0	0	0.0	0	0.0
Clark	2	0.7	2	0.6	3	0.9	2	0.6	3	0.9	2	0.6
Columbia	0	0.0	0	0.0	0	0.0	1	23.4	1	24.6	0	0.0
Cowlitz	5	5.6	2	2.2	1	1.1	1	1.1	7	7.5	7	7.5
Douglas	0	0.0	1	3.2	0	0.0	0	0.0	0	0.0	1	3.0
Ferry	1	14.0	0	0.0	0	0.0	1	13.8	0	0.0	0	0.0
Franklin	1	2.2	1	2.1	1	2.1	1	2.1	0	0.0	4	7.9
Garfield	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grant	1	1.5	5	7.1	2	2.8	2	2.7	2	2.7	1	1.3
Grays Harbor	0	0.0	2	2.9	1	1.5	1	1.5	0	0.0	2	2.9
Island	0	0.0	0	0.0	0	0.0	3	4.3	0	0.0	0	0.0
Jefferson	0	0.0	0	0.0	1	3.9	0	0.0	0	0.0	1	3.8
King	22	1.3	26	1.5	24	1.4	46	2.7	35	2.0	33	1.9
Kitsap	0	0.0	1	0.4	1	0.4	4	1.7	2	0.9	0	0.0
Kittitas	1	3.1	2	6.2	0	0.0	1	2.9	3	9.0	0	0.0
Klickitat	0	0.0	1	5.4	0	0.0	3	16.0	0	0.0	0	0.0
Lewis	0	0.0	1	1.5	3	4.4	0	0.0	2	2.9	1	1.4
Lincoln	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Mason	0	0.0	0	0.0	1	2.1	2	4.1	2	4.0	1	2.0
Okanogan	1	2.6	0	0.0	2	5.1	1	2.5	1	2.5	1	2.5
Pacific	0	0.0	0	0.0	0	0.0	1	4.8	1	4.8	0	0.0
Pend Oreille	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pierce	4	0.6	8	1.2	6	0.9	9	1.3	12	1.7	2	0.3
San Juan	0	0.0	0	0.0	0	0.0	0	0.0	1	7.1	0	0.0
Skagit	6	6.3	11	11.2	3	3.0	13	12.7	16	15.5	4	3.8
Skamania	0	0.0	0	0.0	0	0.0	1	10.4	0	0.0	0	0.0
Snohomish	10	1.9	17	3.1	10	1.7	20	3.4	20	3.3	5	0.8
Spokane	11	2.7	12	2.9	5	1.2	12	2.9	11	2.6	11	2.6
Stevens	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5	0	0.0
Thurston	3	1.5	2	1.0	5	2.5	3	1.5	6	2.9	1	0.5
Wahkiakum	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Walla Walla	1	1.8	1	1.8	0	0.0	0	0.0	1	1.8	0	0.0
Whatcom	2	1.3	5	3.2	6	3.7	5	3.0	11	6.6	7	4.1
Whitman	0	0.0	1	2.5	1	2.4	0	0.0	0	0.0	0	0.0
Yakima	3	1.3	12	5.4	29	13.0	58	25.9	30	13.5	20	8.9
Total	77	1.4	124	2.2	112	1.9	199	3.4	170	2.9	113	1.9

* Excludes Detox, Transitional Housing & Group Care Enhancement, private pay admissions. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Heroin Per 100,000 in Population





Washington State Department of Social Health Services Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Youth Treatment Admissions* Primary Drug = Heroin

County Name	SFY 1996		SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	0	0.0	1	6.2	0	0.0	0	0.0	0	0.0
Asotin	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Benton	1	0.8	1	0.7	0	0.0	1	0.7	0	0.0	1	0.7
Chelan	0	0.0	0	0.0	0	0.0	1	1.5	0	0.0	1	1.5
Clallam	0	0.0	1	1.6	0	0.0	1	1.6	0	0.0	0	0.0
Clark	3	1.0	4	1.3	3	0.9	4	1.2	0	0.0	1	0.3
Columbia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cowlitz	1	1.1	2	2.2	4	4.4	3	3.2	12	12.9	10	10.6
Douglas	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Ferry	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Franklin	0	0.0	2	4.2	0	0.0	0	0.0	0	0.0	0	0.0
Garfield	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grant	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	1.3
Grays Harbor	0	0.0	0	0.0	0	0.0	1	1.5	0	0.0	0	0.0
Island	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Jefferson	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
King	11	0.7	16	1.0	23	1.4	21	1.2	12	0.7	15	0.9
Kitsap	0	0.0	0	0.0	0	0.0	1	0.4	3	1.3	0	0.0
Kittitas	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Klickitat	0	0.0	0	0.0	1	5.4	0	0.0	1	5.2	1	5.2
Lewis	0	0.0	2	3.0	1	1.5	0	0.0	3	4.4	0	0.0
Lincoln	0	0.0	1	10.1	1	9.9	0	0.0	0	0.0	0	0.0
Mason	0	0.0	2	4.2	0	0.0	0	0.0	0	0.0	0	0.0
Okanogan	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pacific	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pend Oreille	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pierce	7	1.1	4	0.6	4	0.6	2	0.3	2	0.3	1	0.1
San Juan	0	0.0	0	0.0	1	7.6	0	0.0	0	0.0	0	0.0
Skagit	1	1.0	9	9.2	6	6.0	8	7.8	4	3.9	1	1.0
Skamania	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Snohomish	5	0.9	0	0.0	6	1.0	3	0.5	4	0.7	4	0.6
Spokane	6	1.5	3	0.7	1	0.2	3	0.7	0	0.0	1	0.2
Stevens	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Thurston	6	3.1	3	1.5	7	3.5	7	3.4	6	2.9	2	1.0
Wahkiakum	0	0.0	0	0.0	0	0.0	1	25.8	1	26.2	0	0.0
Walla Walla	0	0.0	0	0.0	0	0.0	0	0.0	1	1.8	0	0.0
Whatcom	2	1.3	1	0.6	1	0.6	3	1.8	4	2.4	4	2.3
Whitman	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Yakima	9	4.0	4	1.8	0	0.0	6	2.7	15	6.7	15	6.7
Total	52	0.9	55	1.0	60	1.0	66	1.1	68	1.2	58	1.0

* Excludes Detox, Transitional Housing & Group Care Enhancement, private pay admissions. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Completion

Treatment Completion Improves Patient Outcomes

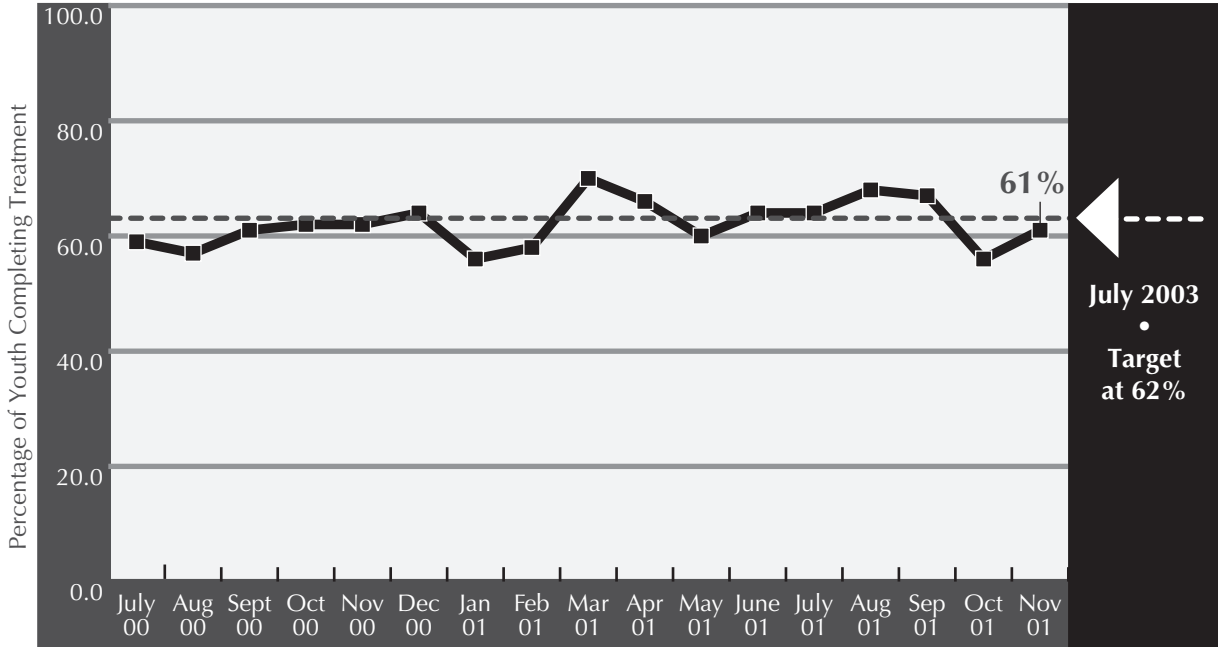
As part of a Department of Social and Health Services' pledge to ensure better outcomes for state residents it serves, the Division of Alcohol and Substance Abuse (DASA) has committed itself to improving completion and retention rates for publicly funded patients receiving chemical dependency treatment. This focus is soundly based in the science of addiction:

- *A 1993 New Jersey study indicates that clients who complete the first 28 days of treatment have more favorable outcomes (lower medical care utilization, fewer psychiatric hospitalizations, less criminal involvement) than those who are admitted to treatment but who do not complete the treatment.*[1]
- *The extended recovery rate (abstinent 15-18 months after discharge) of adolescents who successfully complete treatment is significantly higher (40%) than clients who withdraw or are discharged from treatment against medical advice (26%) or because of rule violations (29%).*[2]
- *The extended recovery rate of adolescents (66%) who are discharged from inpatient treatment, and complete aftercare services such as peer support groups and/or further treatment, is twice that of adolescents who are discharged from treatment and who do not complete aftercare services (30%).*[3]
- *Adults completing an inpatient program for patients with co-occurring substance abuse and mental illness were 39% less likely to be admitted to a psychiatric hospital in the year after treatment, and 27% less likely to use emergency medical services than adults who did not complete the inpatient program.*[4]
- *Pregnant women who complete treatment are more likely to have full-term deliveries, babies with higher birth weights, and fewer fetal or infant deaths than pregnant women who receive no treatment or leave before completing treatment.*[5]
- *Adults completing a full continuum of treatment have higher post-treatment wages from employment ($403/month) than clients who leave before completing treatment ($310/month) or who receive no treatment ($265/month).*[6]
- *Adult clients who left long term residential treatment early were 9 times more likely to have spent time in jail 6-months post discharge than clients who completed their treatment.*[7]

DASA is now working with researchers, counties, tribes, and both residential and outpatient treatment providers to set targets and incorporate best practices to improve completion rates throughout the state.

[1] Hoffmann, N., Dehart, S., & Fulkerson, J. (1993). Medical care utilization as a function of recovery status following chemical addictions treatment. Journal of Addictive Diseases Vol. 12.
[2] New Standards, Inc. (1997). Washington State Division of Alcohol and Substance Abuse 18-month adolescent outcomes report. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.
[3] Ibid.
[4] Cox, Gary, & Maynard, Charles. (1998). Evaluation of Pioneer Center North. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.
[5] Washington State MOMS Project. (1999). Washington State MOMS Project: Perinatal research and demonstration project. Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse.
[6] (Wickizer, T., Joesch, J., Longhi, D., Krupski, A., & Stark, K., (1997). Employment outcomes of indigent clients receiving alcohol and drug treatment in Washington State. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.
[7] Carney, M., & Donovan, D. (1999). Washington State Outcomes Project: An evaluation of the publicly funded adult residential treatment system 6 months post discharge. Olympia, WA: Division of Alcohol and Substance Abuse, Department of Social and Health Services.

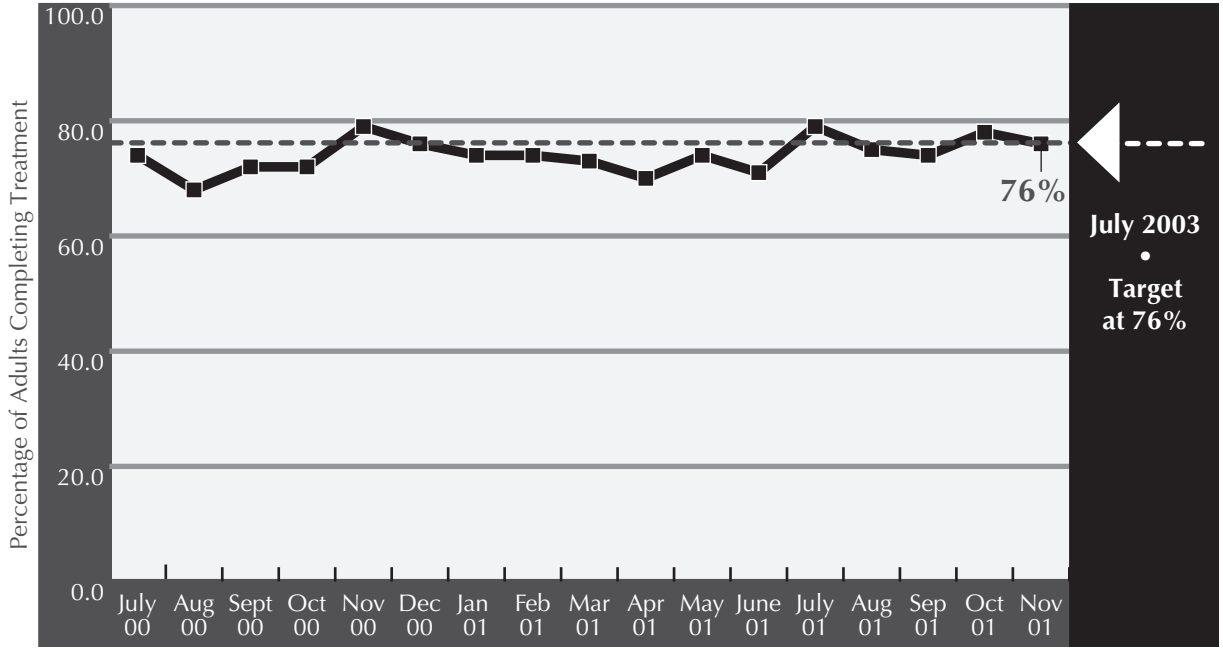
Residential Chemical Dependency Treatment Completion Rates for Youth Now Equal the July 2003 Target of 62%.



Source: Program Review, Division of Alcohol and Substance Abuse, January 2002.

The Division of Alcohol and Substance has set a goal of increasing the percentage of low-income youth who complete publicly funded residential chemical dependency treatment. Cumulative data from July-November 2001 indicate that 64% of youth completed treatment.

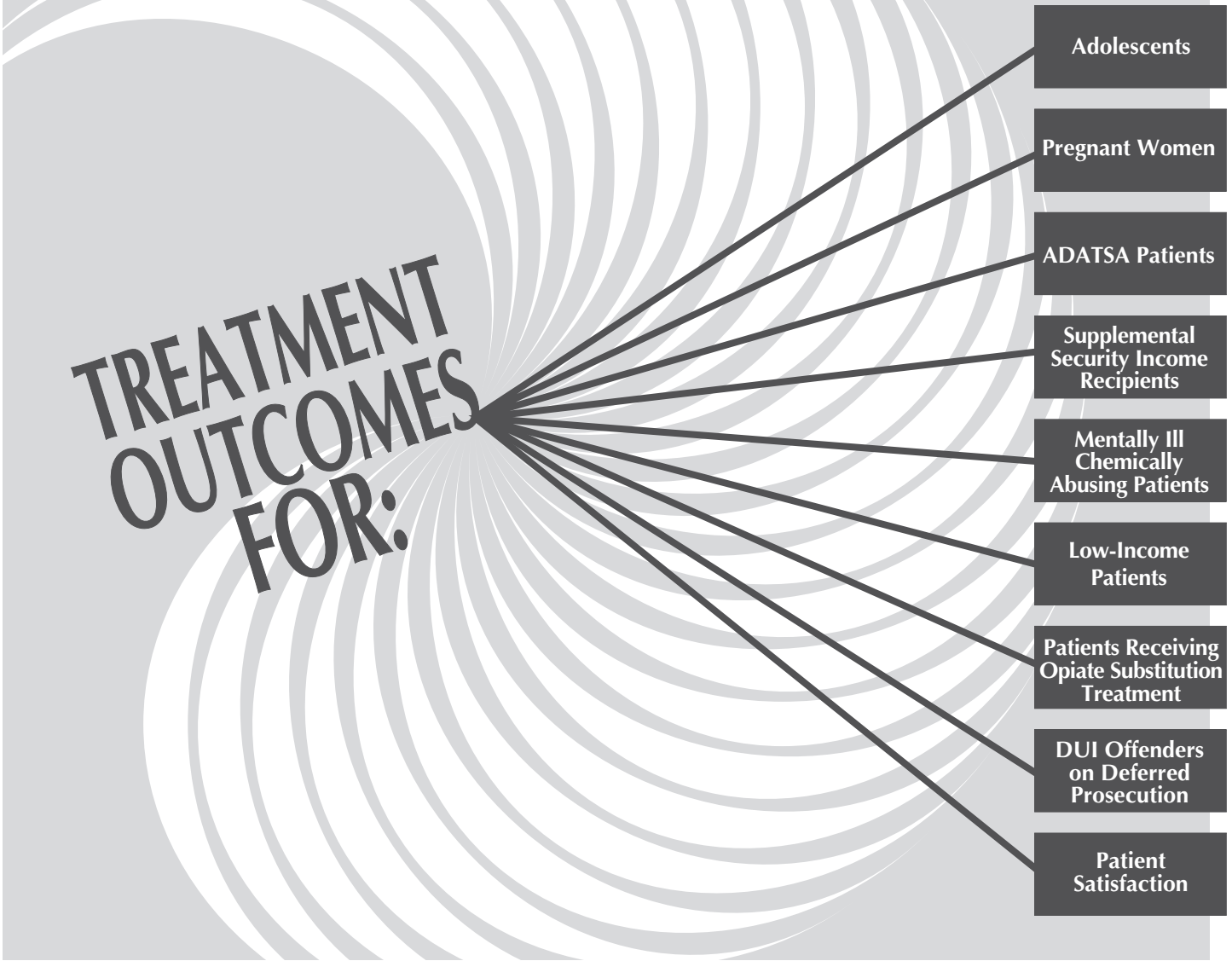
Residential Chemical Dependency Treatment Completion Rates for Adults Now Equal the July 2003 Target of 76%.



Source: Program Review, Division of Alcohol and Substance Abuse, January 2002.

The Division of Alcohol and Substance has set a goal of increasing the percentage of low-income adults who complete publicly funded residential chemical dependency treatment. Cumulative data from July-November 2001 indicate that 76% of youth completed treatment, equaling the July 2003 target.

Outcomes: The Benefits of Prevention & Treatment



The Work of the DASA Research and Evaluation Section

The Division of Alcohol and Substance Abuse's Research and Evaluation Section was created to respond to the need to demonstrate the effectiveness of substance abuse prevention and treatment in serving the overall mission of the Department of Social and Health Services (DSHS), "to improve the quality of life for individuals and families in need." Through research and evaluation activities, DASA is able to document the role of alcohol- and drug-related services in enhancing client self-sufficiency; protecting vulnerable adults, children, and families; and assuring public safety and helping to build strong, healthy communities. Research also aids in the development of "best practices" that can be utilized by chemical dependency treatment providers in improving the quality of care, and provides the scientific basis for the development of sound public policy.

DASA's productivity in research and evaluation is due, at least in part, to the strong partnership it has developed with the research community over the last decade. This is most evident in the 70-member Research Subcommittee of the Citizen's Advisory Council on Alcoholism and Drug Addiction. Members are drawn from research institutions throughout the Northwest. DASA also coordinates a statewide "Bridging the Gaps" Workgroup, which seeks to forge new partnerships among researchers, prevention and treatment providers, and policymakers

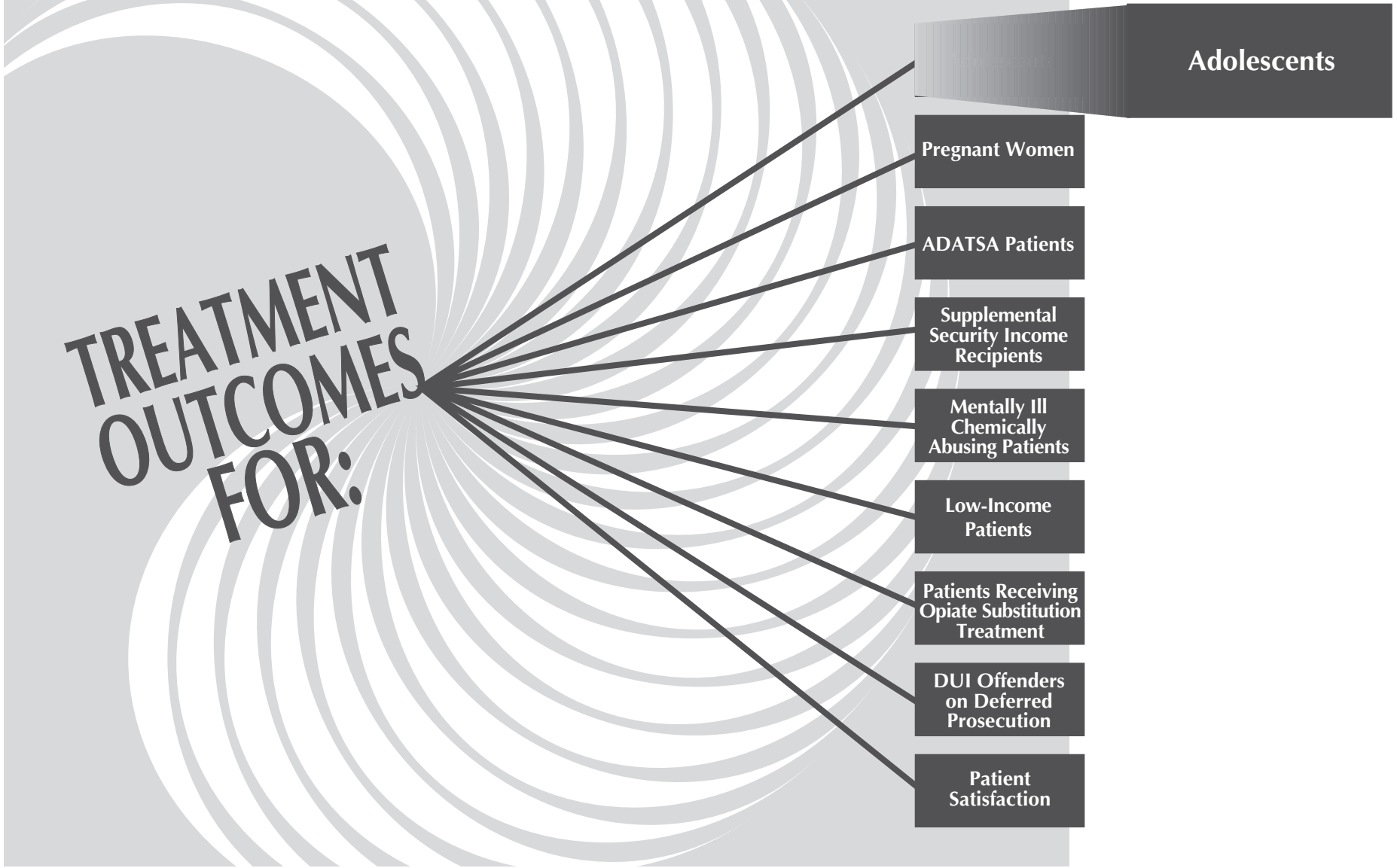
Current Research Efforts

Some of the results of outcomes research conducted under the auspices of DASA on the benefits of prevention and treatment are displayed on the following pages. Below is a partial list of research projects currently underway:

- Methadone vs. Drug-Free Outpatient Treatment for Opiate Addicts
- Arrestee Drug Abuse Monitoring Project
- Study of the Effect of Student Learning Environment and Peer Substance Use on School Performance
- Analysis of Use, Cost, and Outcomes of Chemical Dependency Treatment Services in Oregon and Washington
- Evaluation of Washington State Drug-Free Workplace Program
- Follow-up of Former Washington State SSI/SSDI Recipients Diagnosed with Drug Addiction and Alcoholism
- Statewide Household Survey to Assess Need for Treatment Among Adults in Washington State
- Treatment Outcomes of Persons with Co-Occurring Mental Health and Substance Abuse Disorders
- Outcomes of Pregnant, Postpartum, and Parenting Women Who Receive Specialized Chemical Dependency Services
- Criminal Justice Outcomes of Youth Who Participate in Chemical Dependency Treatment

In addition, the Research and Evaluation Section is assisting in development of a web-based client outcome tracking system for use by providers, county coordinators, and state-level managers.

Outcomes: The Benefits of Prevention & Treatment



Profile of Adolescents Served in Publicly Funded Chemical Dependency Programs in Washington

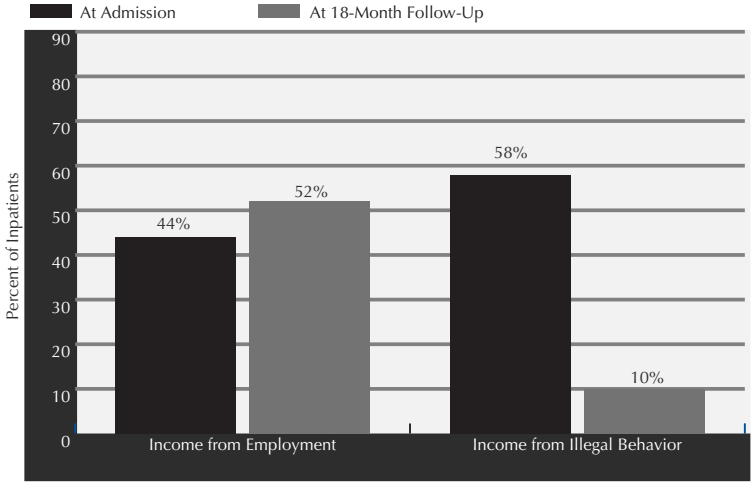
A 1999 study of adolescents (age 20 and younger) admitted to publicly funded chemical dependency treatment in Washington State revealed the following profile:

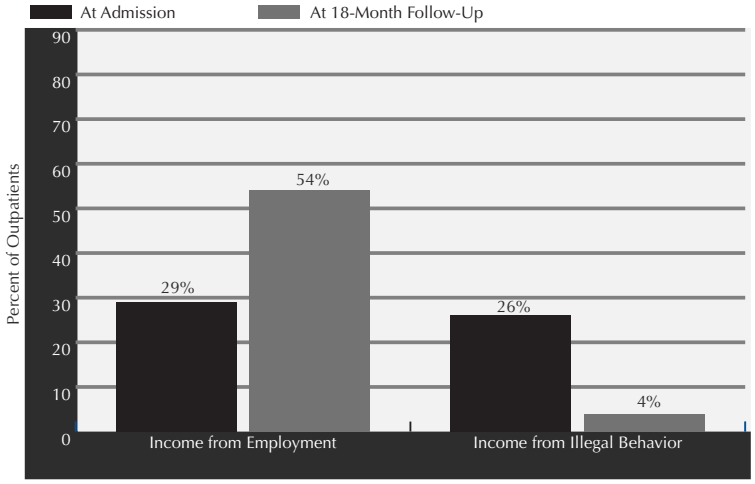
- Between 55-70% of youth admitted to residential treatment had run away from home at least once in their lives.
- Between 23-34% of youth had one or more emergency room visit in the year prior to admission.
- Between 68-78% of youth reported having one or more arrests in the year prior to admission.
- More than 62% of youth reported some form of involvement with the criminal justice system at time of admission.
- 90% of youth admitted to treatment began using their primary substance of abuse prior to age 16.
- Between 70-90% reported at time of admission that they currently smoke cigarettes.
- Between 23-37% of those admitted to residential treatment had been domestic violence victims.
- 89% of those admitted for treatment did not have a high school degree at time of admission; only 65% were enrolled in school full- or part-time.[1]

The graphs on the following pages indicate the effectiveness of treatment in promoting positive outcomes among adolescents.

[1] Rodriguez, F. (1999). Profile of youth clients admitted to publicly funded substance abuse treatment programs in Washington State, 1998. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

A Greater Number of Adolescents Reported Income Earned from Employment, and Less Income from Illegal Behavior After Treatment.

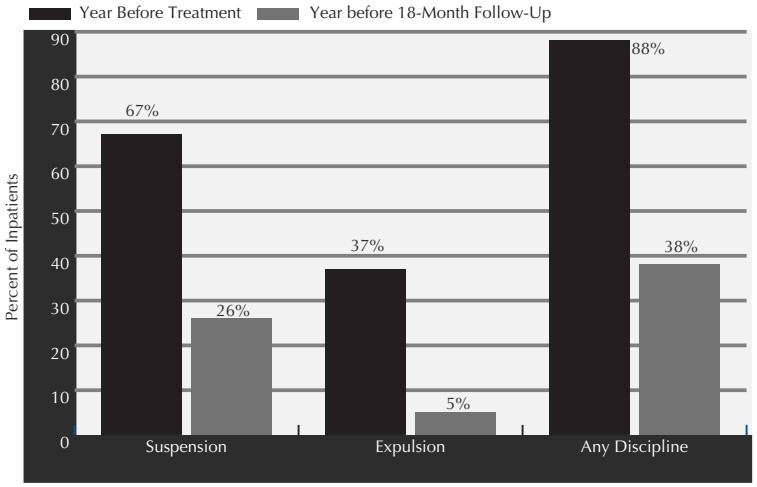


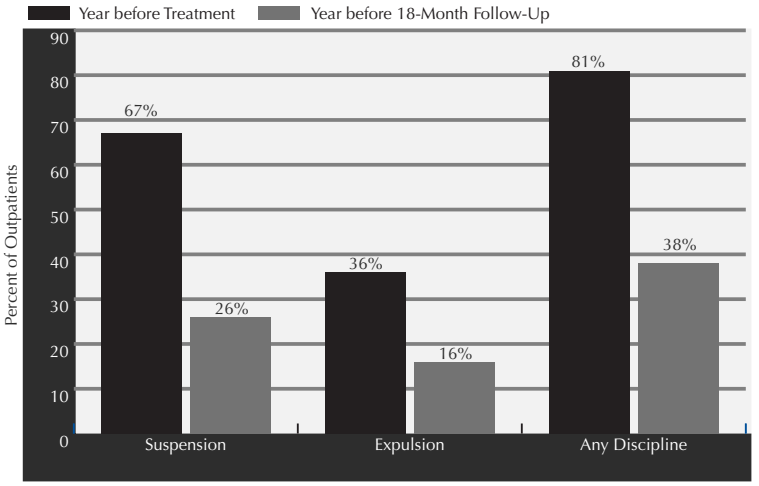


Source: New Standards, Inc. (1997). Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report. St. Paul, MN: New Standards, Inc.

At the time of admission, adolescent inpatients were more likely to report income from illegal behavior than from legitimate employment, while outpatients were almost equally as likely to report income from both sources. At the time of the 18-month follow-up, however, adolescents who had been in both inpatient and outpatient treatment were 5 times more likely to report income from employment rather than illegal behavior.

School Discipline Problems for Adolescent Patients Decreased After Treatment.

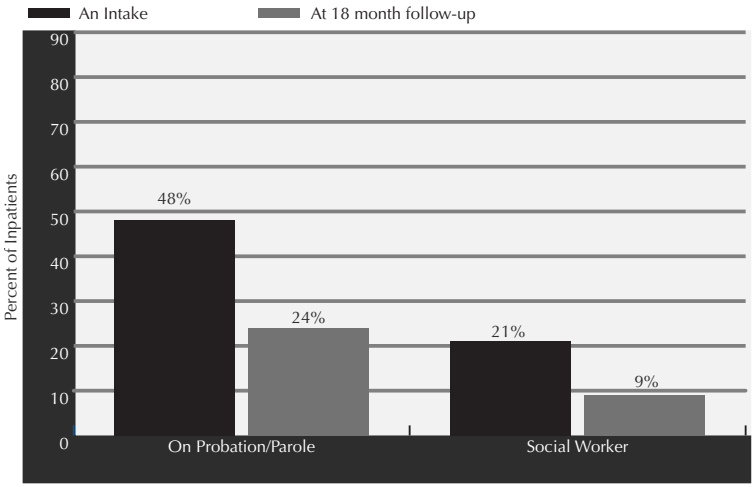


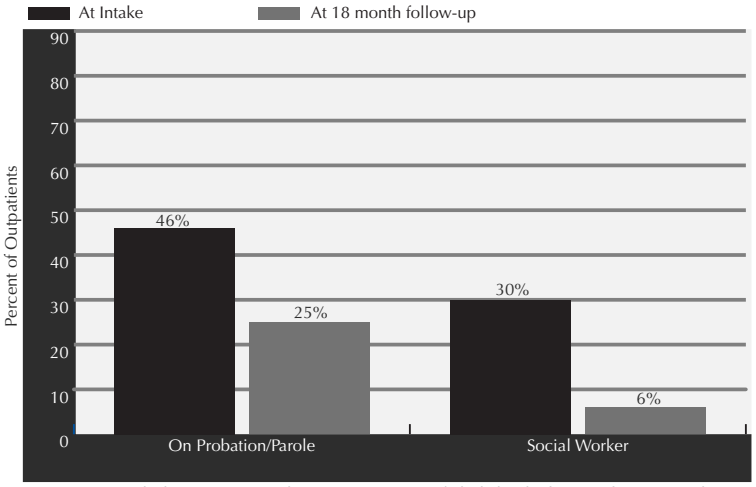


Source: New Standards, Inc. (1997). Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report. St. Paul, MN: New Standards, Inc.

Not surprisingly, adolescents with substance abuse problems tend to experience behavioral problems when attending school. After substance abuse treatment, however, the number of adolescents reporting any school discipline problems in the preceding year dropped by 50%. An especially encouraging outcome is the substantial reduction in school expulsions for youth receiving either inpatient or outpatient treatment. Additional study results also showed a corresponding improvement in school grades after treatment.

A Lower Percentage of Adolescent Patients were Under Legal Supervision 18 Months After Treatment.



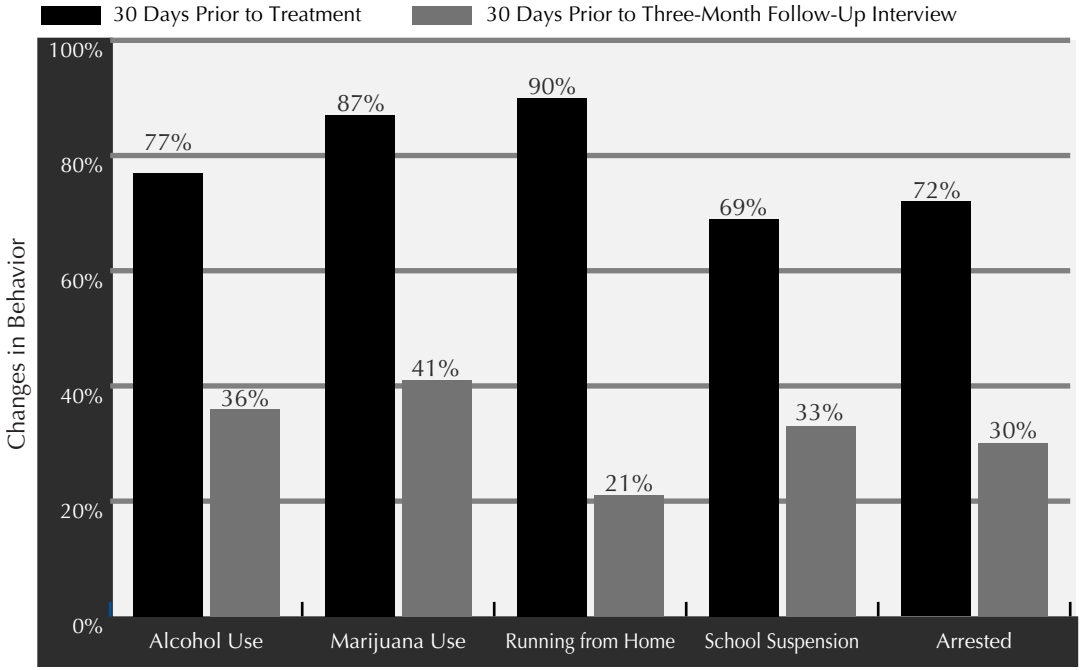


Source: New Standards, Inc. (1997). Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report. St. Paul, MN: New Standards, Inc.

A large proportion of children involved in the juvenile justice system have substance abuse problems, and similarly, a large portion of juveniles in chemical dependency treatment programs are involved in criminal activities. Therefore, it is expected that obtaining substance abuse treatment will have a positive effect on criminal behavior as well as decreasing or ceasing substance use.

As expected, legal involvement by adolescents decreased considerably after treatment for both inpatients and outpatients. Compared to their status at intake, approximately half as many adolescents were on parole or probation at the time of follow-up. There was a similar reduction in supervision by social workers for inpatients, and only 6% of outpatients were under a social worker's supervision at the 18 -month follow-up, compared to 30% at intake.

"Becca" Youth Who Complete Residential Chemical Dependency Treatment Are Much Less Likely to Use Alcohol or Marijuana, Less Likely to Run Away from Home, and Less Likely to Be Suspended from School or Arrested.

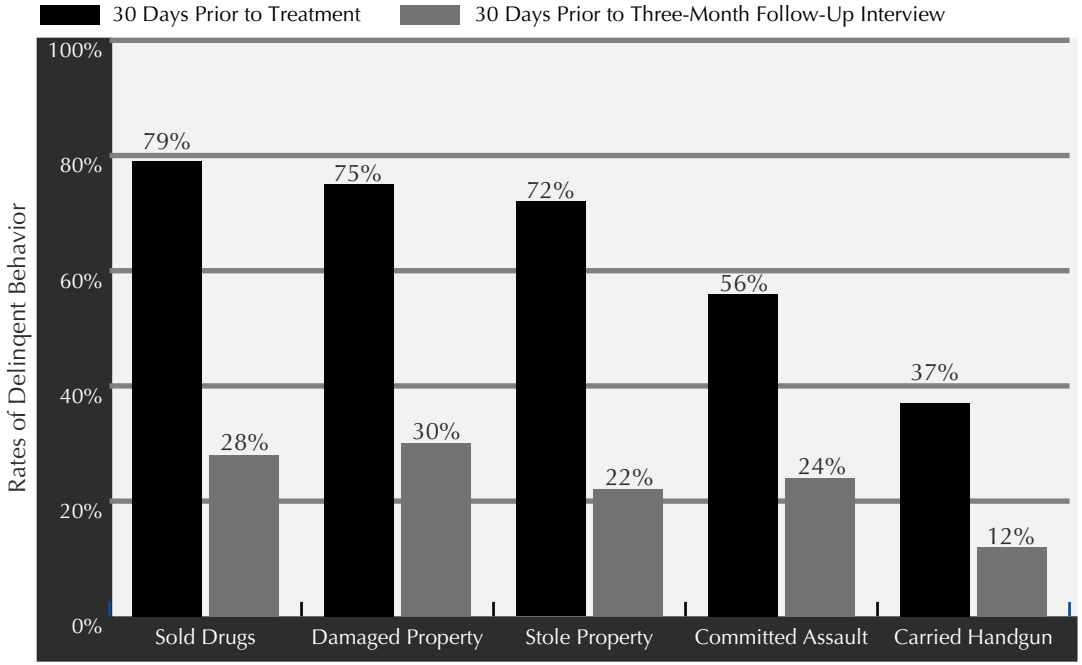


Source: Peterson, P., Srebnik, D., Banta-Green, C., Baxter, B. (1997). Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the "Becca" Bill. Seattle, WA: Alcohol and Drug Abuse Institute, University of Washington.

The 1995 At-Risk/Runaway Youth Act created the "Becca" program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent's control and/or are chronic runaways. These youth are estimated at approximately 3-4% (1,350 to 2,250) of the 45,000 youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14 to 16.

While the needs of Becca Youth are very high, this graph indicates that residential chemical dependency treatment results in significant positive changes in behavior following treatment completion.

Rates of Delinquent Behavior Among "Becca" Youth Decline Substantially Following Completion of Residential Chemical Dependency Treatment.

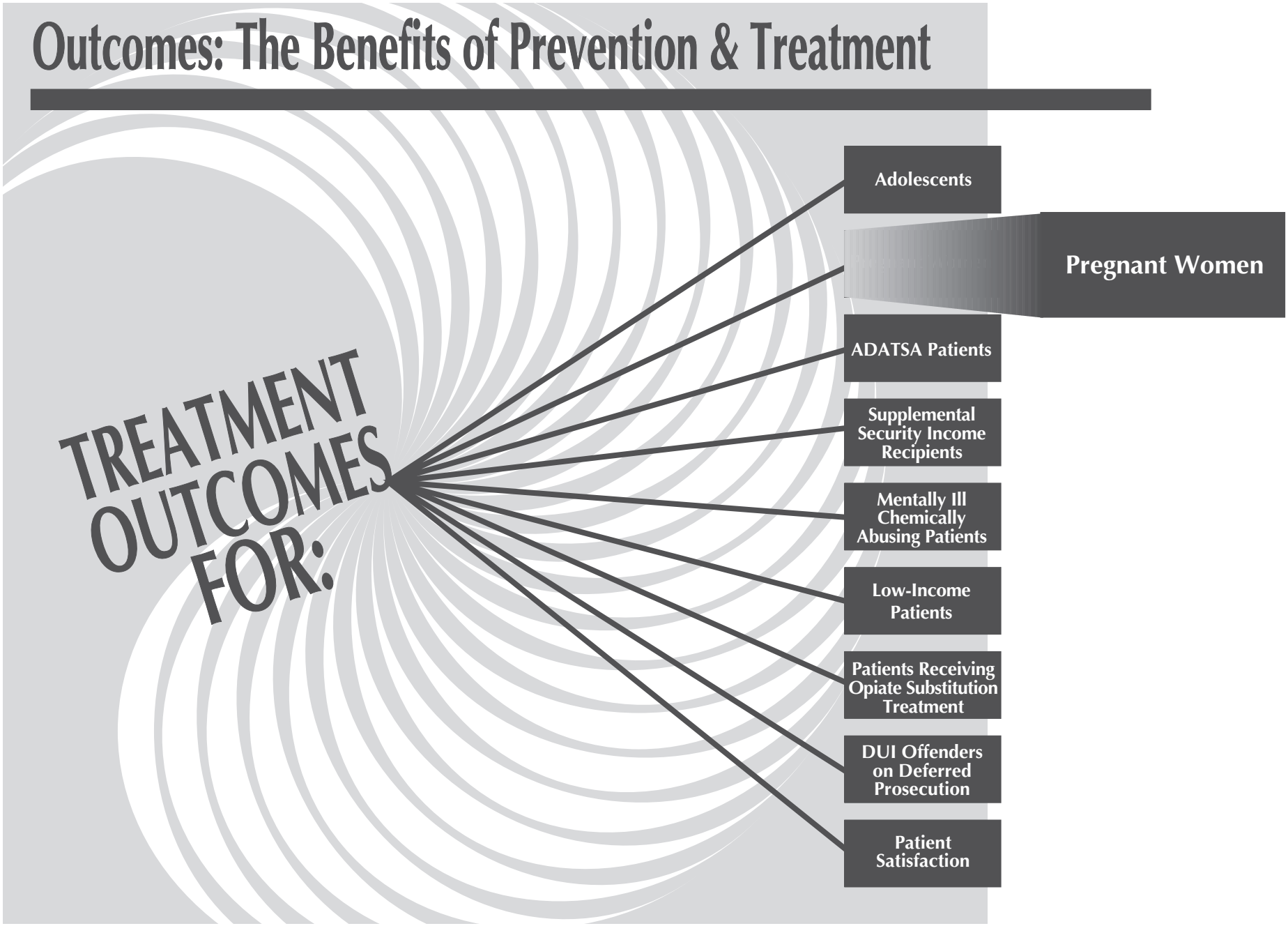


Source: Peterson, P., Srebnik, D., Banta-Green, C., Baxter, B. (1997). Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the "Becca" Bill. Seattle, WA: Alcohol and Drug Abuse Institute, University of Washington.

This graph indicates that Becca youth who receive chemical dependency treatment are much less likely to engage in delinquent behavior following treatment completion. In this 1997 study conducted by the University of Washington, the percentage of Becca youth involved in selling drugs declined by 64.6%; those stealing property dropped by 60.4%; and the percentage of those who committed assault dropped by 57.1%.

The 1995 At-Risk/Runaway Youth Act created the "Becca" program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent's control and/or are chronic runaways. These youth are estimated at approximately 3-4% (1,350 to 2,250) of the 45,000 youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14 to 16.

Outcomes: The Benefits of Prevention & Treatment



Chemically dependent pregnant, post-partum, and/or parenting women (PPWs) present significant challenges and opportunities to both treatment providers and policy makers. As mothers or mothers-to-be, PPWs and their children have a range of medical, social, and residential needs that must be met if treatment is to succeed. However, successful treatment results in outcomes that benefit not only women, but their children, entire families, and communities.

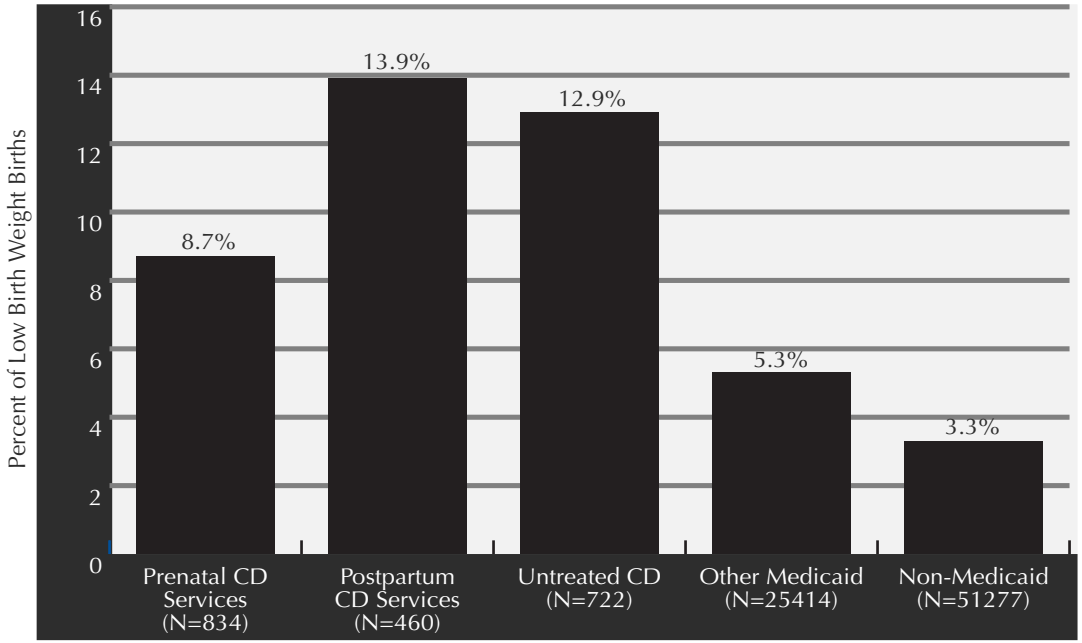
A 1999 study of PPWs admitted to publicly funded chemical dependency treatment in Washington State revealed the following profile:

- More than 60% of PPWs admitted to treatment had been victims of domestic violence.
- Up to 15% reported being homeless.
- Over 50% reported public assistance as their primary source of income.
- Between 38-73% had visited an emergency room one or more times in the year prior to treatment admission.
- Over one-quarter reported having received mental health treatment in the year prior to admission.
- More than 60% had been arrested in the year prior to admission; between 50-66% were involved with the criminal justice system at time of admission.
- Between 26-63% reported having used injection drugs.
- Between 77-92% reported they currently smoke cigarettes.[1]

The graphs on the following pages indicate the effectiveness of treatment in promoting positive outcomes for PPWs and their children.

[1] Rodriguez, F. (1999). Profile of pregnant, post-partum, and/or parenting women (PPW) admissions to publicly funded substance abuse treatment programs in Washington State, 1998. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

Substance Abusing Women Who Received Chemical Dependency Treatment Prenatally were Less Likely to Have a Low Birth Weight Baby.



Source: Cawthon, L. (1993). Substance Abuse in Pregnancy. First Steps Database, 3 (1).

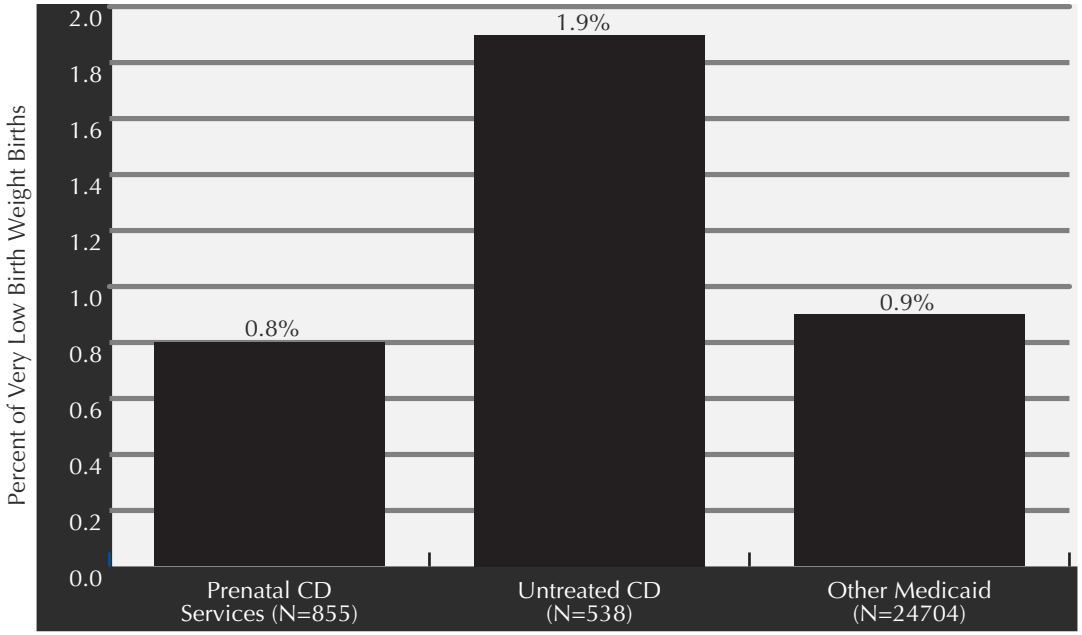
Note: **Prenatal CD Services** refers to women who received substance abuse treatment during the prenatal period.
Postpartum CD Services refers to women who were diagnosed as substance abusers in the year after delivery and were neither diagnosed nor treated during the prenatal period.
Untreated CD refers to women diagnosed as substance abusers during the prenatal period but did not receive substance abuse treatment in the prenatal period.
Other Medicaid refers to women with Medicaid funded maternity services who were not identified as substance abusers.
Non-Medicaid refers to women with no Medicaid payments for maternity services who were not identified as substance abusers.

According to Cawthon, birth weight is a primary indicator of the health of the newborn infant.[1] Newborn infants weighing less than 5.5 pounds (2500 grams) are considered low birth weight. Low birth weight is associated with increased risk of death and a wide range of disorders including neuro-developmental conditions, learning disorders, behavior problems, and lower respiratory tract infection.

Fewer low birth weight babies among women who participate in chemical dependency treatment means that treatment is associated with healthier babies.

[1] Cawthon, L. (1993) Substance abuse in pregnancy, Washington State Department of Social and Healther Services, First Steps Database 3 (1).

The Rate of Very Low Birth Weight Babies (<1,500 Grams) Born to Substance-Abusing Women Who Received Prenatal Chemical Dependency Treatment was Less than Half That of Untreated Substance-Abusing Women.



Source: Cawthon, L. & Schrager, L. (1995). Substance Abuse, Treatment, and Birth Outcomes for Pregnant and Postpartum Women in Washington State. First Steps Database, 5 (1).

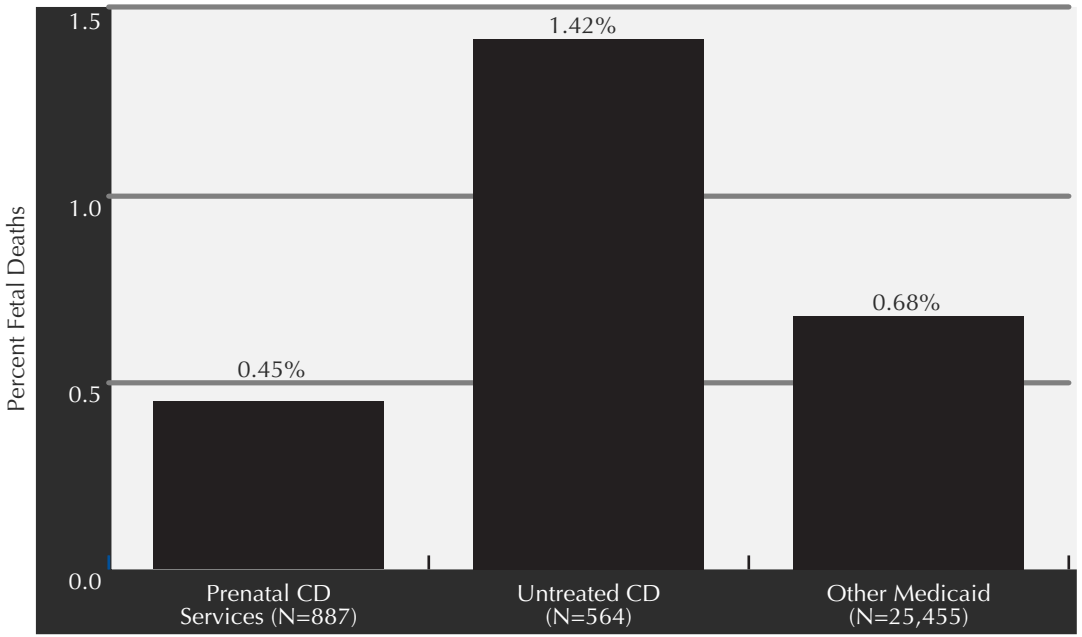
Note: **Prenatal CD Services** refers to women who received substance abuse treatment during the prenatal period.
Untreated CD refers to women diagnosed as substance abusers during the prenatal period but did not receive substance abuse treatment in the prenatal period.
Other Medicaid refers to women with Medicaid funded maternity services who were not identified as substance abusers.

According to ***Healthy People 2000***, about 26% of very low birth weight infant survivors had moderate or severe disabilities.[2] These include I.Q.'s below 80, cerebral palsy, major seizure disorders, and blindness. Aside from the personal and emotional costs, such disabilities place a continuing financial burden on the family and may eventually limit the child's ability to work and earn a living in adulthood.

Fewer very low birth weight babies among women who participate in chemical dependency treatment means that treatment

[1] U.S. Public Health Service (1990). Healthy People 2000. National health and disease prevention objectives (p. 326). Washington DC: U.S. Department of Health and Human Services.

The Fetal Death Rate for Substance-Abusing Pregnant Women was One-Third That of Untreated Substance Abusing Pregnant Women.

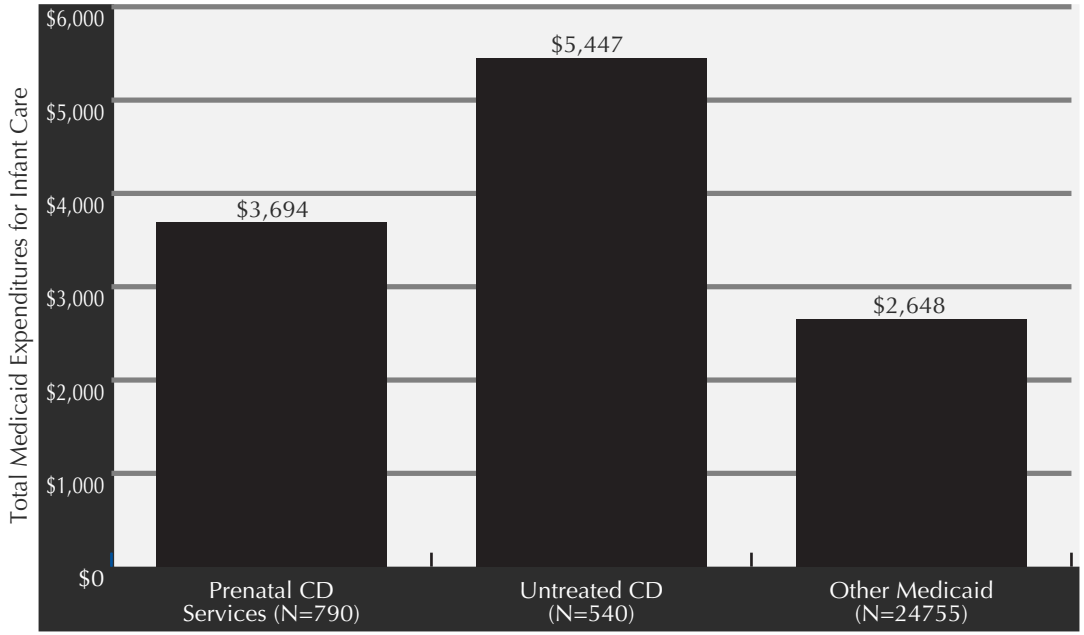


Source: Cawthon, L. & Schrager, L. (1995). Substance Abuse, Treatment, and Birth Outcomes for Pregnant and Postpartum Women in Washington State. First Steps Database, 5 (1).

Note: **Prenatal CD Services** refers to women who received substance abuse treatment during the prenatal period.
Untreated CD refers to women diagnosed as substance abusers during the prenatal period but did not receive substance abuse treatment in the prenatal period.
Other Medicaid refers to women with Medicaid funded maternity services who were not identified as substance abusers.

Fetal death, or stillbirth, is associated with pregnancies complicated by maternal medical conditions including substance abuse. Fewer fetal deaths among women who participate in chemical dependency treatment means that such treatment is associated with healthier babies.

Average Medicaid Costs During the First Two Years of Life were Lower for Infants Born to Women Who Received Chemical Dependency Treatment in the Prenatal Period than for Those Born to Substance-Abusing Women Who Did Not Receive Treatment.

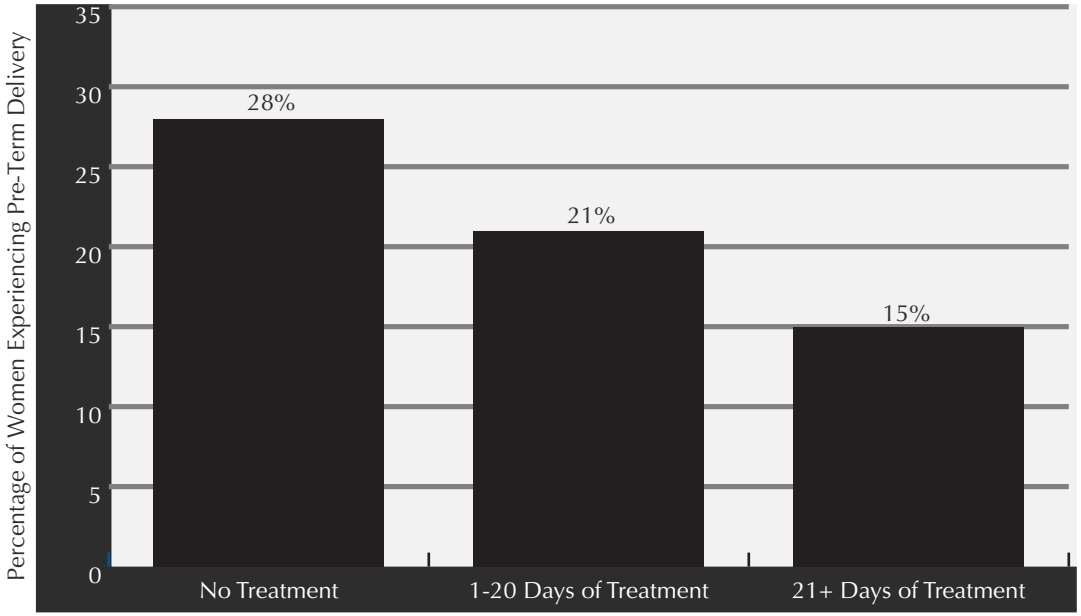


Source: Cawthon, L. & Schrager, L. (1995). Substance Abuse, Treatment, and Birth Outcomes for Pregnant and Postpartum Women in Washington State. First Steps Database, 5 (1).

Note: **Prenatal CD Services** refers to women who received substance abuse treatment during the prenatal period.
Untreated CD refers to women diagnosed as substance abusers during the prenatal period but did not receive substance abuse treatment in the prenatal period.
Other Medicaid refers to women with Medicaid funded maternity services who were not identified as substance abusers.

Low birth weight is the single most important factor in determining infant medical care expenditures during the neonatal period. The average Medicaid expenditure for infant care during the first two years of life for infants born to untreated substance abusers was 1.4 times that for the infants of women who received prenatal substance abuse treatment and more than twice that for infants of other (non-substance abusing) Medicaid women.

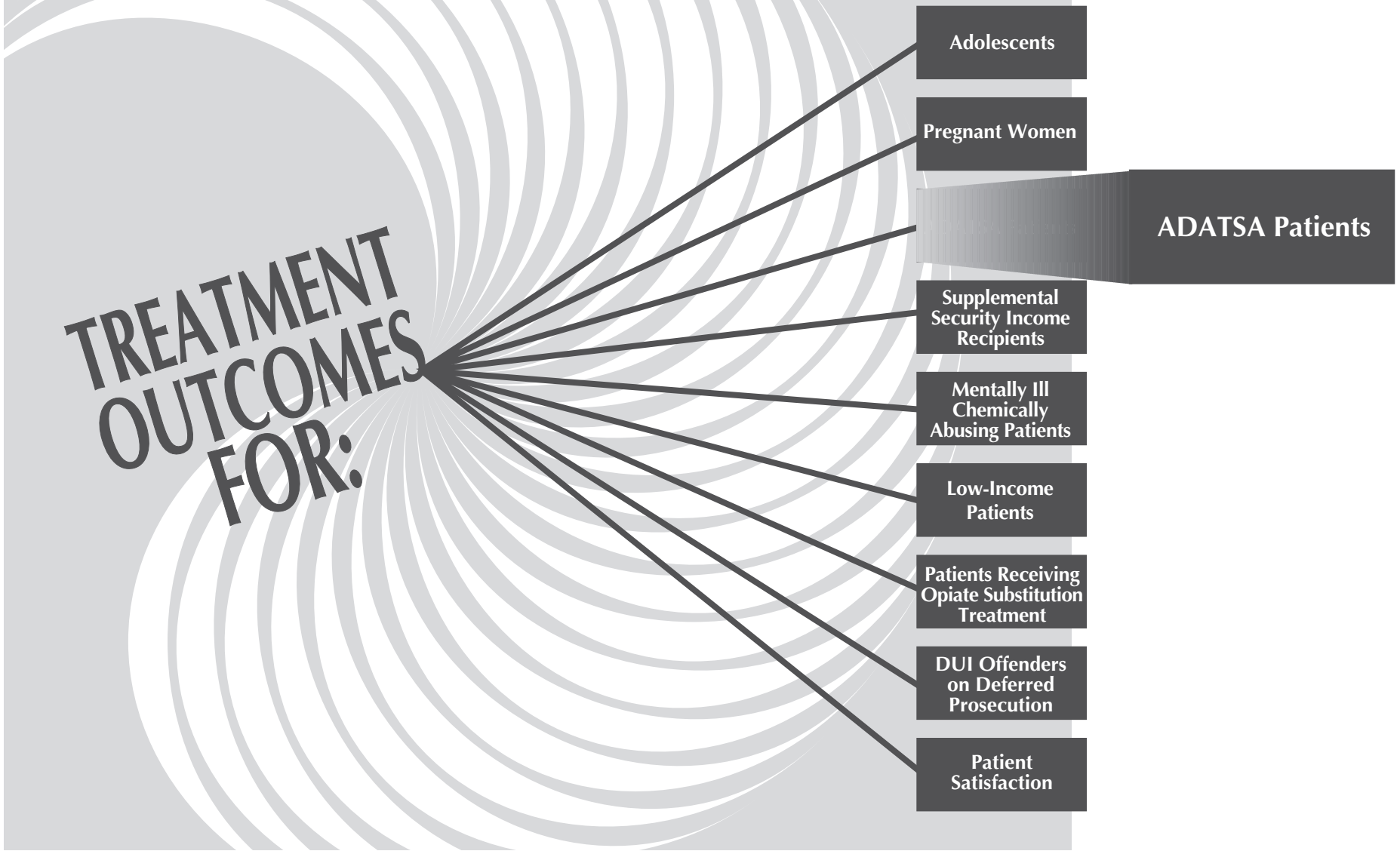
Pregnant, Substance-Abusing Women Who Receive 21+ Days of Chemical Dependency Treatment are Much Less Likely to Experience a Pre-Term Delivery Than Women Who Do Not Receive Treatment.



Source: Washington State Division of Alcohol and Substance Abuse. (1999). Washington State MOMS Project: Perinatal Research and Demonstration Project – Final Report.

A 1999 National Institute on Drug Abuse-funded study of the MOMS Project, which delivered woman-specific chemical dependency treatment services to pregnant women in Washington State in need of them, found a 46.4% reduction in pre-term deliveries for women who remained in treatment for 21 days or longer. Treatment was also associated with lower rates of fetal or infant death, lower rates of placental abruption, and improved birth outcomes.

Outcomes: The Benefits of Prevention & Treatment



Chemical Dependency Treatment is Associated with Positive Outcomes Among ADATSA Patients

In 1999, 6,979 Washington residents received chemical dependency treatment under the Alcohol and Drug Addiction and Support Act (ADATSA). Enacted in 1987, this legislation created a program to treat adults addicted to alcohol or other drugs. To qualify, clients must be indigent, unemployable, and incapacitated due to their addiction. A maximum of six months of treatment and financial support is provided in any two-year period. The immediate goal of the program is abstinence, while ancillary goals include improved personal coping skills, as well as social and vocation skills. Success in moving toward these goals is expected to result in improving in reach the long-term objective of self-sufficiency.

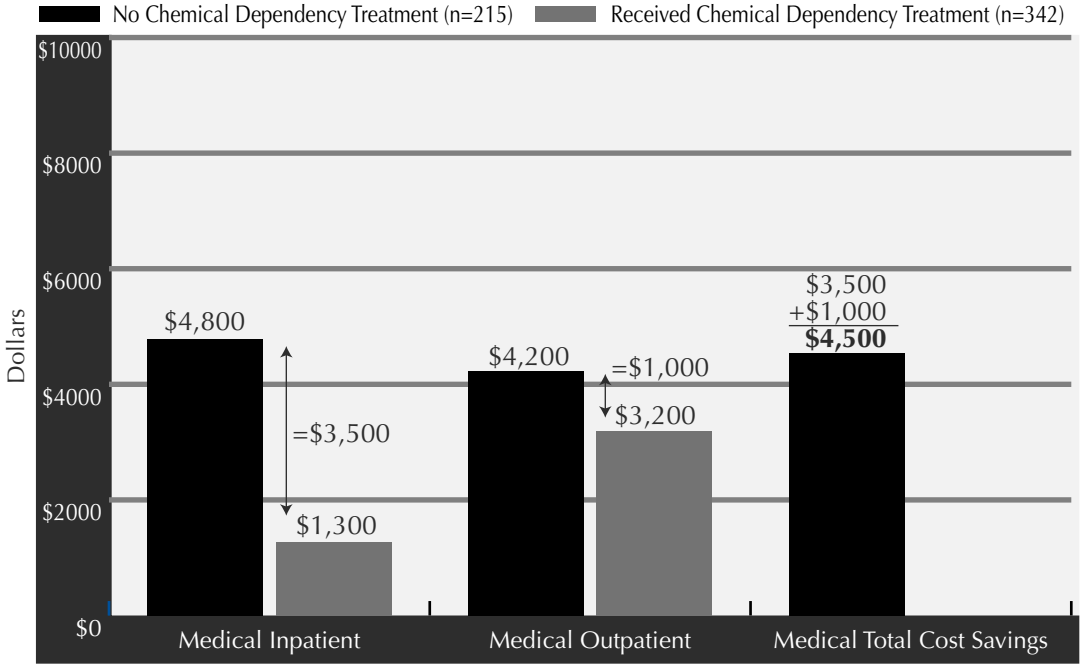
The typical ADATSA patient is an unmarried, white male in his early thirties, often homeless, living alone or with non-relatives, and often involved with the criminal justice system. One-third of patients are female, and one-third of patients are ethnic minorities. The average patient has had a 15-year history of substance abuse starting at age 16, with one or more prior treatment episodes. A significant number have physical, mental, or emotional problems.[1]

A group of 151 ADATSA patients who had completed a continuum of care were studied to determine the outcome of treatment six months after treatment. Key findings included:

- 79.5% had been abstinent for the past three months.
- 39.7% had been employed full-time and 21.9% had been employed part-time in the past three months.
- 80.8% attended Alcoholics Anonymous meetings in the past three months; 33.1% received aftercare services during the same time period.[2]

[1] Brown, M., Longhi, D., Luchansky, B. (1997). Employment outcomes of chemical dependency treatment and additional vocatioin services publicly funded by Washington State: A four-and-a-half year follow-up study of indigent persons served by Washington's State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis.
[2] Van Der Hyde, V., Kamara, S., Holman, E., Clegg, D., West, B. (1995). ADATSA follow-up study of extended outpatient care: A comparison of 90 days versus 180 days of outpatient treatment for clients of Washington State's Alcoholism and Drug Addiction Treatment and support Act. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis.

Average Medical Costs for ADATSA Patients Who Received Chemical Dependency Treatment were $4,500 Lower than Those for Untreated Patients Over a Five-Year Follow-Up Period.

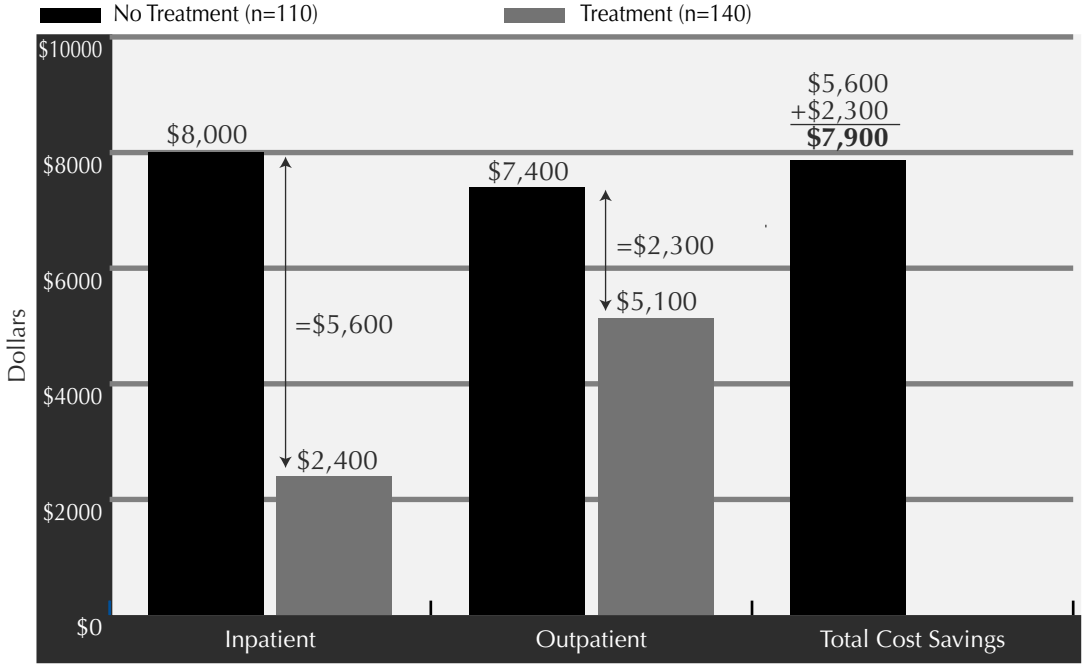


Source: Office of Research and Data Analysis, Washington State Department of Social and Health Services, 1997.

This graph indicates that chemical dependency treatment can result in lower medical expenses. Over a five-year period, treated ADATSA patients had medical costs averaging $4,500 less than those who did not receive treatment. Inpatient hospital expenses averaged $3,500 less, while outpatient medical expenses averaged $1,000 less.[1]

[1] Luchansky, B., and Longhi, D. (1997). Cost savings in Medicaid expenses: an outcome of publicly funded chemical dependency treatment in Washington State: A five year cost savings study of indigent persons served by Washington's State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis.

For ADATSA Patients with Medicaid Medical Expenses Prior to Admission, Chemical Dependency Treatment was Associated with $7,900 in Overall Savings in Medical Expenses Over a Five-Year Follow-Up Period.

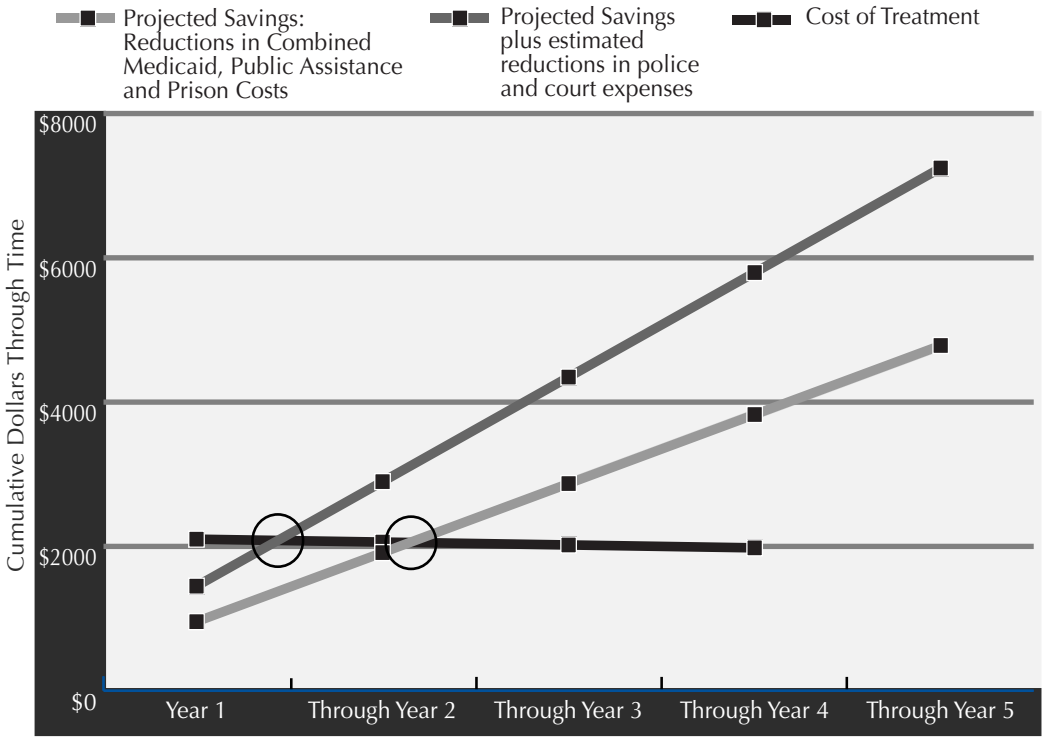


Source: Office of Research and Data Analysis, Washington State Department of Social and Health Services, 1997.

This graph indicates striking savings in medical expenses for ADATSA patients with Medicaid medical expenses prior to admission in the five years following chemical dependency treatment. Overall savings totaled $7,900 — $2,400 in hospital inpatient, and $5,100 in medical outpatient expenses.[1] Chemical dependency treatment is a wise investment, both in the health of ADATSA patients, and in reducing overall health expenses.

[1] Luchansky, B., and Longhi, D. (1997). Cost savings in Medicaid expenses: an outcome of publicly funded chemical dependency treatment in Washington State: A five year cost savings study of indigent persons served by Washington's State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis.

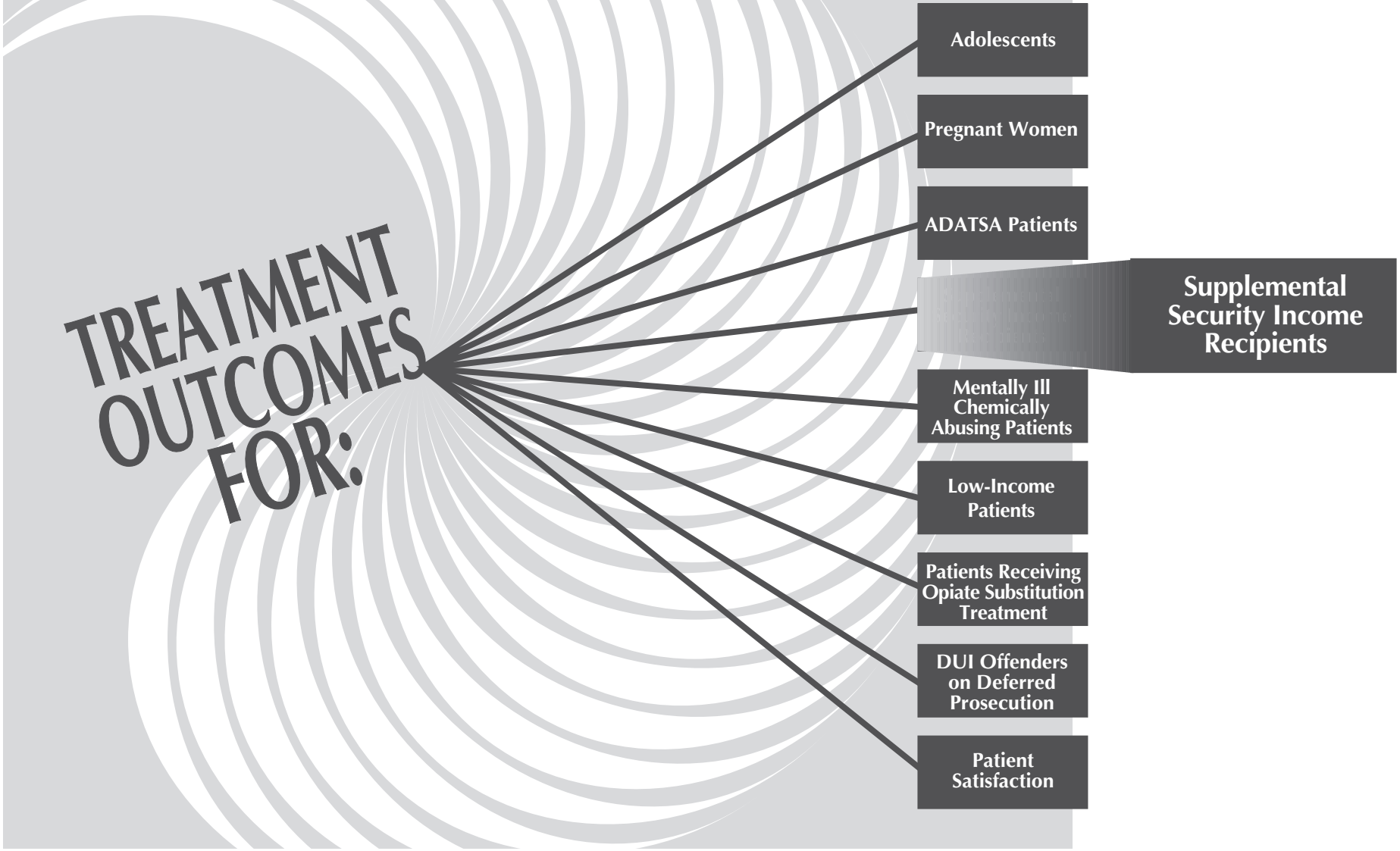
Chemical Dependency Treatment Provided to ADATSA Patients Results in Reduced Costs to the Public Over a Five-Year Follow-Up Period.



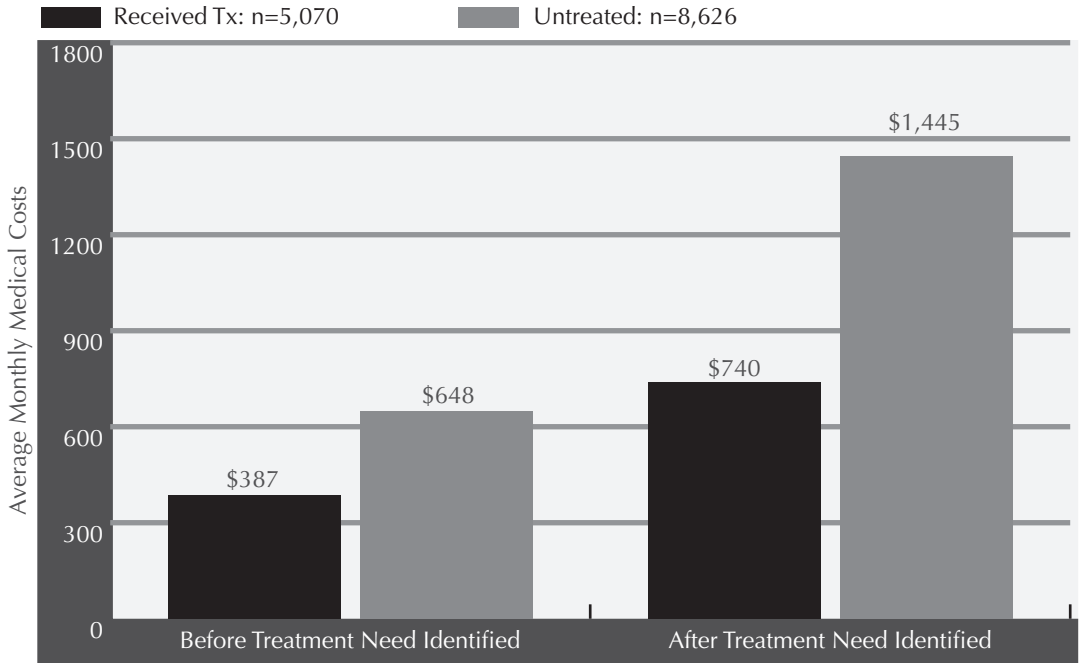
Source: Division of Research and Data Analysis, Washington State Department of Social and Health Services. (1997).

This five year comparison of projected incremental savings with projected treatment costs for ADATSA (Alcoholism and Drug Addiction Treatment and Support Act) patients shows that the overall incremental savings are $7,200, while the cumulative treatment costs total $1,940. This means that every additional dollar spent on the treatment group results in $3.71 in savings by the end of the five year period. When estimated reductions in police and court expenses are added to the projections, the break-even point between costs and savings occurs much sooner. Additional funds spent on treatment pay for themselves in just over one year.

Outcomes: The Benefits of Prevention & Treatment



Chemical Dependency Treatment is Associated with Much Lower Medical Costs Among Supplemental Security Income (SSI) Recipients.



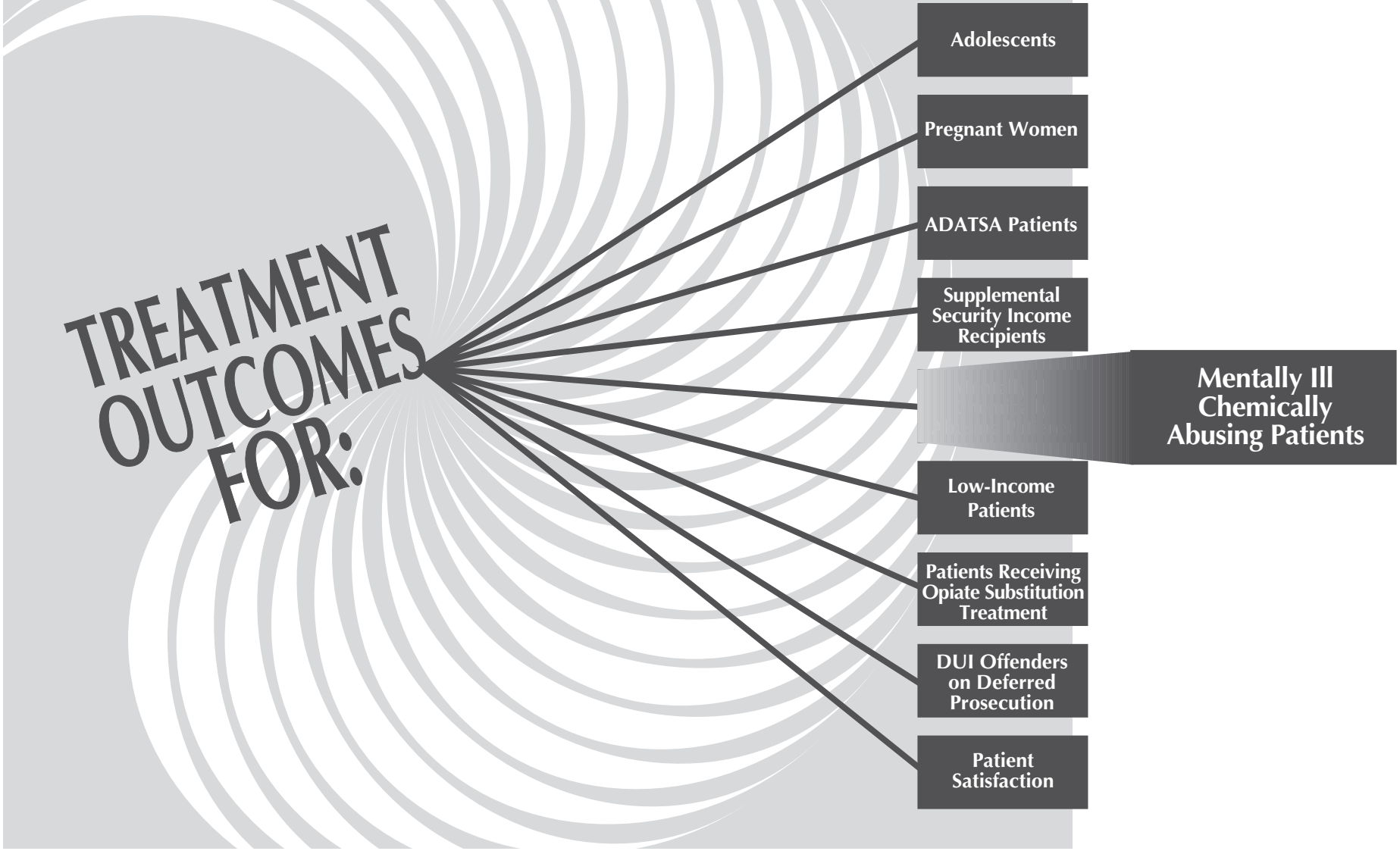
Source: Estee, S. & Nordlund, D. (2001). Washington State Supplemental Secutiy Income Cost Offset Pilot Project: 2001 Progreess Report. Olympia, WA: Department of Social and Health Services, Research and Data Analysis.

Medical and chemical dependency treatment records for nearly 104,000 adult Social Security Insurance (SSI) recipients were examined to determine need for and receipt of chemical dependency treatment services. Of these recipients, 13% were in need of treatment, and 38% of those in need received treatment between July 1997 and December 2000.

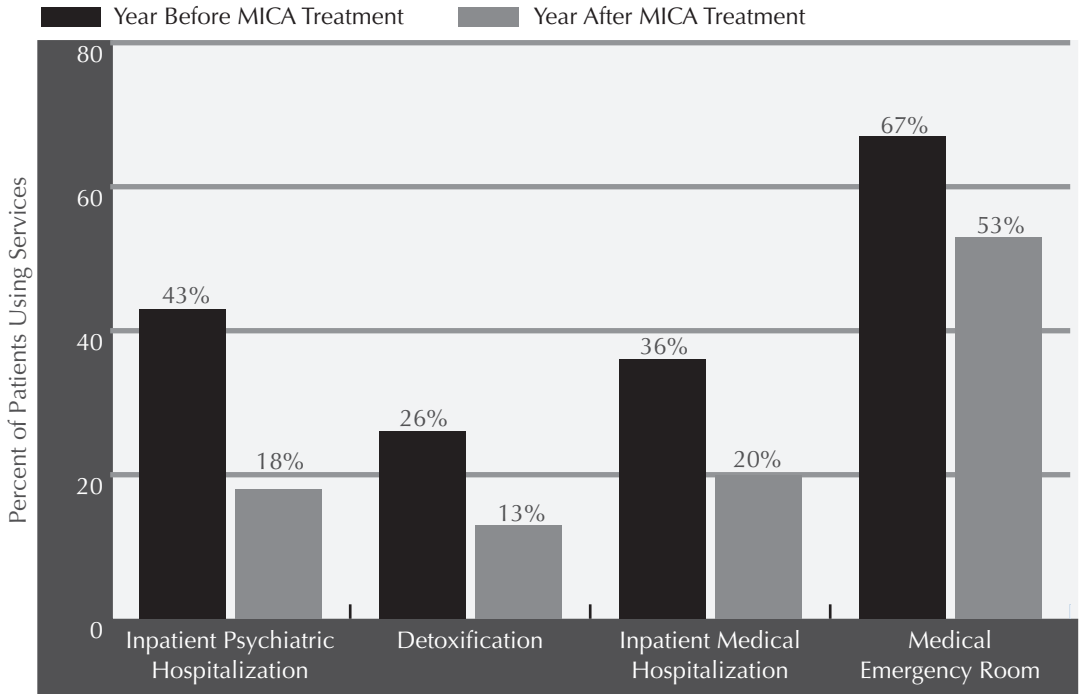
Medical cost differences between those who received treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical costs, the average monthly medical costs were $540 higher for those not receiving chemical dependency treatment than for those who received at least some treatment, or a yearly cost differential of $6,480. The Division of Alcohol and Substance Abuse has now expanded services in its SSI Cost Offset Pilot Project, and is contracting with the Department of Social and Health Services, Research and Data Analysis Division to examine differences in mental health and criminal justice costs and in mortality resulting from chemical dependency treatment.

[1]Estee, S., & Nordlund, D. (2001). Supplemental Security Income (SSI) cost offset pilot project: 2001 progress report. Olympia, WA: Department of Social and Health Services, Research and Data Analysis.

Outcomes: The Benefits of Prevention & Treatment



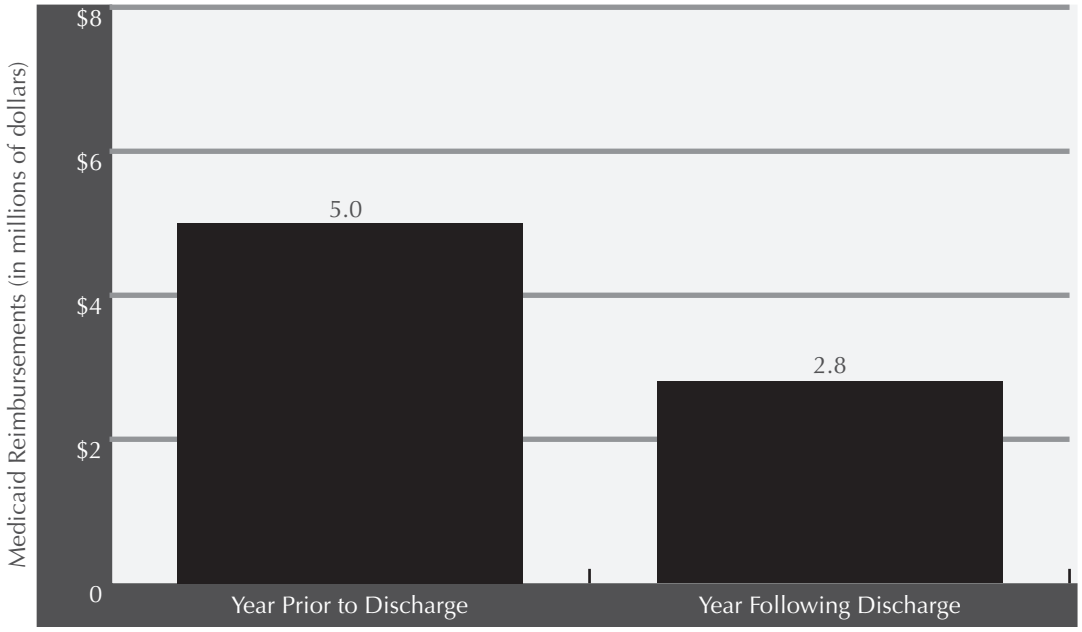
Mentally Ill Chemically Abusing Patients Utilize Fewer Medicaid Services Following Discharge from Residential Treatment.



Source: Maynard, C., Cox, G., Krupski, A., and Stark, K. (1999). Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment. The Journal of Behavioral Health Services & Research 26:2, May 1999.

A significant number of Medicaid patients receiving residential services are diagnosed with both mental illness and substance abuse disorders. Treating both disorders in an integrated manner has proven effective in enhancing health-related outcomes. This graph indicates that Medicaid expenses for patients receiving coordinated services in a residential setting decreased by 44% in the year following discharge from the year prior to discharge.

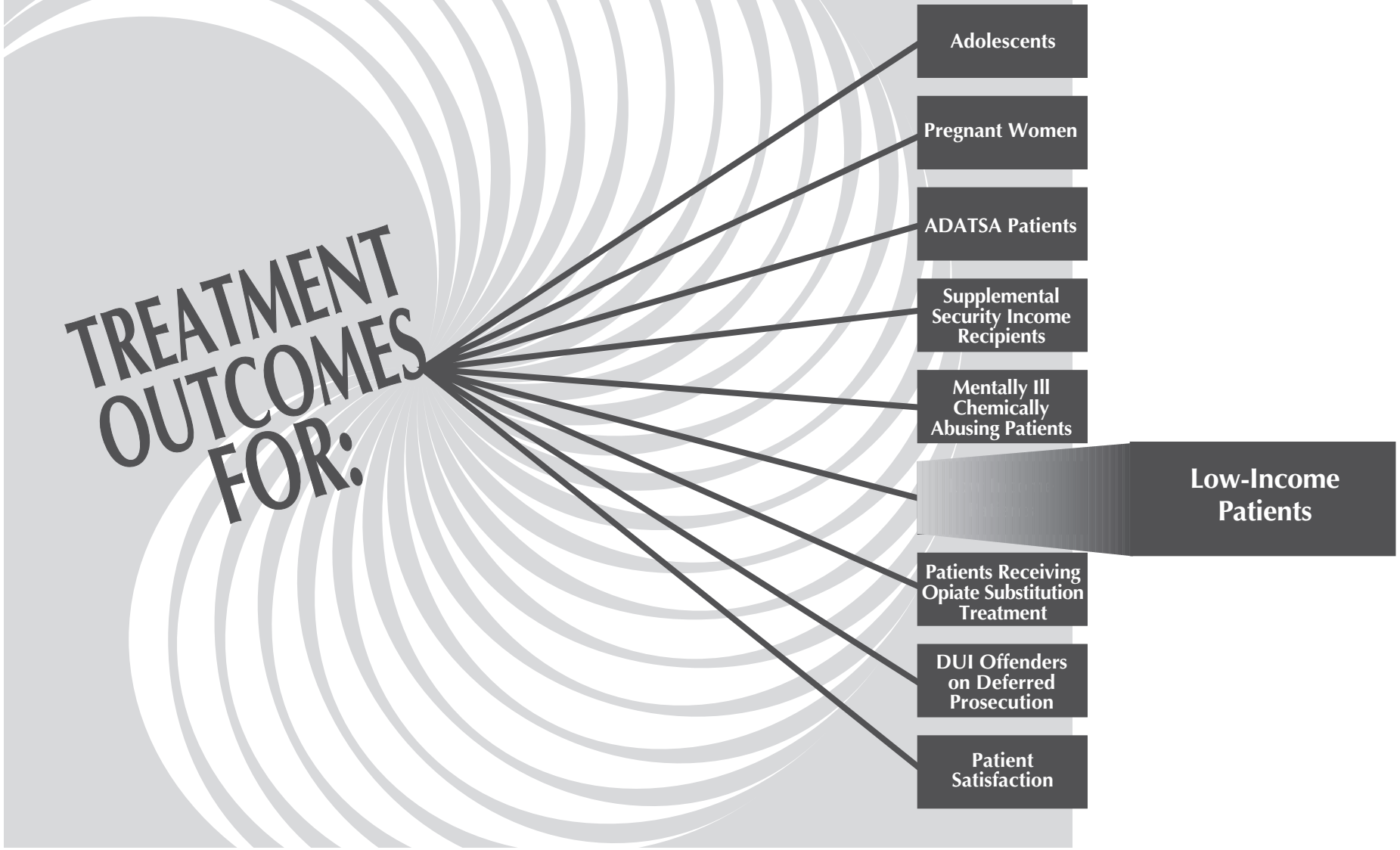
Use of Expensive Acute Care Services Decreased for Mentally Ill Chemical Abusing Patients Following Discharge from Integrated Residential Treatment



Source: Maynard, C., Cox, G., Krupski, A., and Stark, K. (1999). Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment. The Journal of Behavioral Health Services & Research 26:2, May 1999.

Integrated mental health/chemical dependency treatment has proven effective in reducing use of acute care services for mentally ill chemical abusing patients following discharge. The percentage of patients requiring inpatient psychiatric hospitalization fell by 58%; detoxification by 50%; inpatient medical hospitalization by 44%; and use of emergency rooms by 21% in the year following discharge.

Outcomes: The Benefits of Prevention & Treatment



Profile of Adults Receiving Temporary Assistance for Needy Families Admitted to Publicly Funded Chemical Dependency Treatment Programs in Washington

Washington State has made great progress in moving individuals off the welfare rolls and into employment. However, challenges remain in serving individuals who have significant barriers to employment, including substance abuse problems.

A study of adults receiving Temporary Assistance for Needy Families (TANF) admitted to publicly funded treatment in Washington State, July 1998—June 1999, revealed the following profile:

- Those receiving TANF represented 11.1% of adults admitted to publicly funded treatment.
- Almost 80% were women.
- One out of three women did not have a high school diploma or GED.
- Three out of four women reported they had been a victim of domestic violence at some point in their lives.
- 21% reported receiving mental health treatment in the past year.
- 56% of women and 71% of men had one or more arrests in the past year.
- One out of three women reported using injection drugs at some point in their lives.
- Alcohol (44.2%) and stimulants (33.5%) were the most commonly used substances among TANF adults, followed by marijuana (12.7%) and heroin (6.1%).[1]

The information on the following pages indicates the effectiveness of treatment in promoting positive outcomes for low-income adults.

[1] Rodriguez, F. (2000) Key characteristics of TANF adults admitted to publicly funded treatment in Washington State, July 1998 – June 1999. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

Publicly Funded Residential Chemical Dependency Treatment Results in Improved Outcomes in Employment and Medical Status, Lower Substance Use and Higher Rates of Abstinence, and Reduced Criminal Activity.

A 1999 study was undertaken by the University of Washington's Alcohol and Drug Abuse Institute to assess the quality and effectiveness of the Division of Alcohol and Substance Abuse's publicly funded adult residential chemical dependency treatment system. Some 577 low-income patients were assessed at admission to treatment, and six months following their discharge. The study found:

- Patients were much less likely to use alcohol and illegal drugs following treatment. Self-reported abstinence rates for alcohol use in the past 30 days increased by 87%, and by 109% for drug use. Of those who continued to report any drug use, the percentage of patients who used any illegal drugs for seven or more of the past 30 days declined 74%, from 50% at treatment admission to 13% at follow-up.

- The average number of self-reported days of illegal activity declined 85%. Average 30-day earnings from illegal activity declined 93%, from $485 at admission to $32 at follow-up.

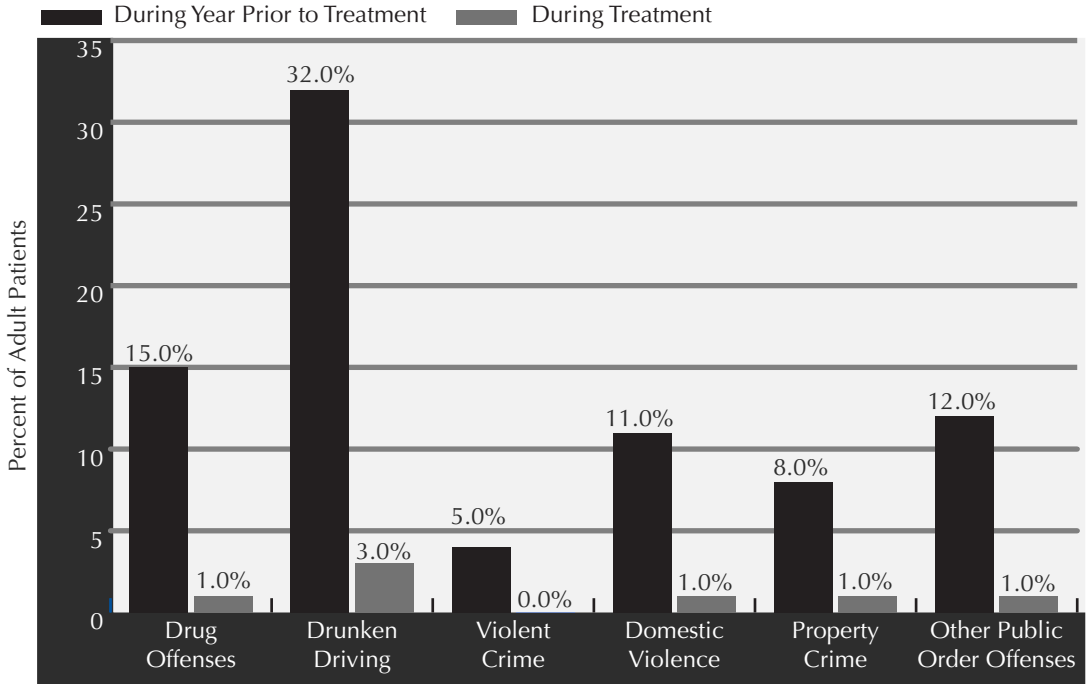
- In the 30 days prior to admission to treatment, only 19.8% of patients worked 10 or more days. In the 30 days prior to the six-month post-discharge follow-up, 40.7% worked 10 or more days, representing a 94% increase. Average monthly income increased from $159 at admission to $568 at follow-up.

- The percentage of patients reporting no days of medical problems during the past 30 days increased by 25% at the post-discharge follow-up. The number of days with mental health distress was reduced by 48%

- The number of days with significant family conflict during the past 30 days declined by 62% at the post-discharge follow-up.[1]

[1] Carney, M., & Donovan, D. (1999). Washington State outcomes project: clinical improvement from the adult residential treatment system 6 months post-discharge. Seattle, WA: University of Washington Alcohol and Drug Abuse Institute.

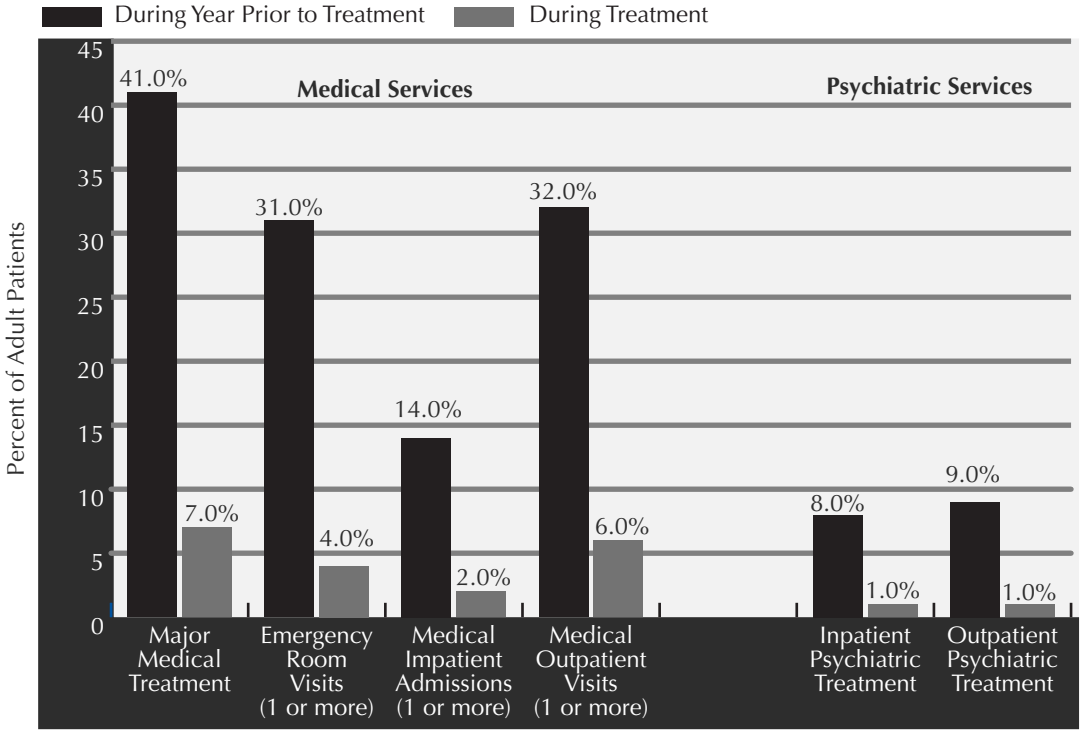
Criminal Arrests Decreased Among Publicly-Funded Chemical Dependency Patients During Outpatient Treatment Compared to the Year Prior to Treatment.



Based on a purposive sample of 11,253 cases.
Source: Baxter, B. L. and Stevenson, J. (1998) Changes in Clients' Alcohol/Other Drug Use and Lifestyles During Publicly - Supported Chemical Dependency Treatment in Washington State: October 1996 - September 1997 Discharges. Seattle, WA: University of Washington Alcohol and Drug Abuse Insititute.

Based on data from the Division of Alcohol and Substance Abuse's management information system (TARGET), fewer adult patients in outpatient treatment were arrested during treatment compared to the year prior to treatment. This suggests an association between chemical dependency treatment and reduced criminal arrests and a possible savings in public resources and in the personal and emotional costs of crime.

Health Services Utilization Decreased among Publicly-Funded Chemical Dependency Patients During Outpatient Treatment Compared to the Year Prior to Treatment.



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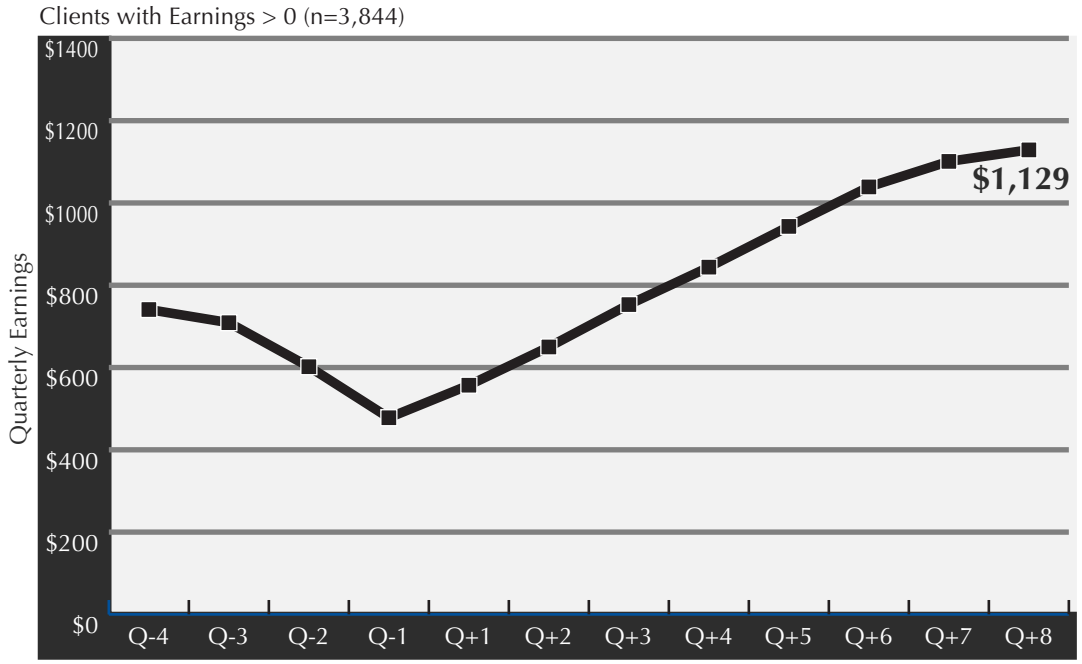
Based on data from the Division of Alcohol and Substance Abuse's management information system (TARGET), fewer adult patients in outpatient treatment accessed medical treatment during treatment compared to the year prior to treatment. This suggests an association between chemical dependency treatment and reduced utilization of medical care services.

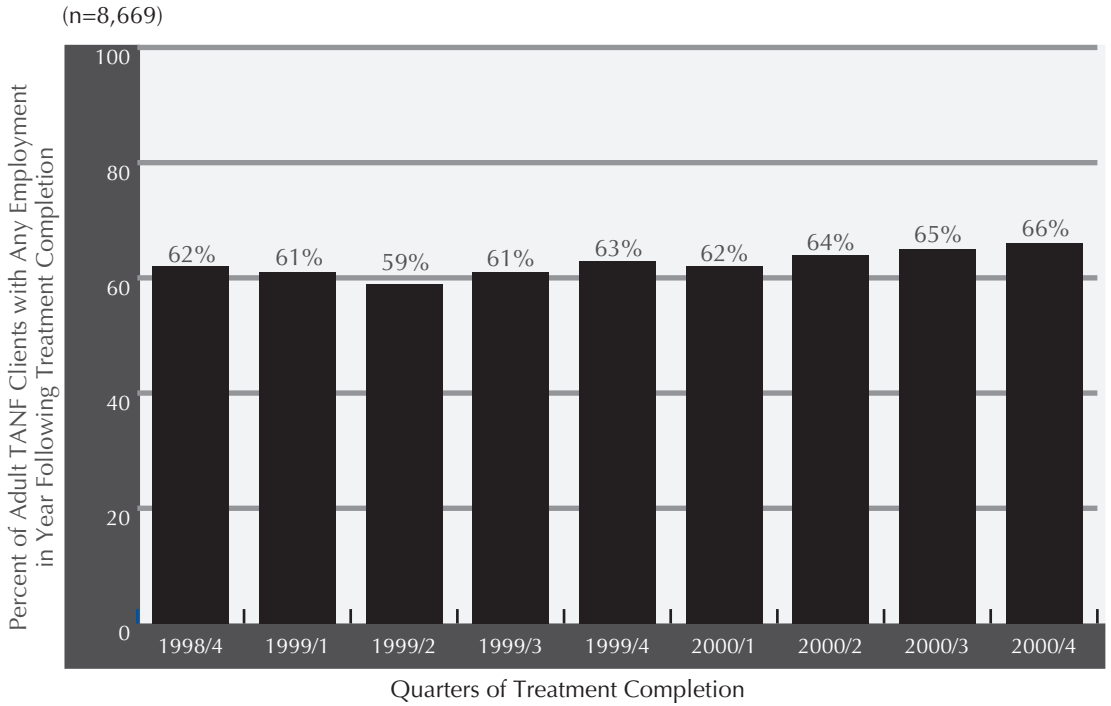
AFDC Clients Who are Employed Show Major Increases in Earnings Following Chemical Dependency Treatment.



Source: Wickizer, T., Campbell, K., Krupskki, A., and Stark, K. (2000). Employment outcomes among AFDC recipients treated for substance abuse in Washington State. The Milbank Quarterly, 78:4, pp. 585-608.

This graph indicates that clients receiving AFDC ("Aid to Families with Dependency Children") support showed marked declines in employment income in the year prior to receiving chemical dependency treatment, and major increases in employment income in the two years following treatment. AFDC in Washington State has now been replaced by the TANF ("Temporary Assistance for Needy Families") program. This study published in 2000 confirms the results of earlier studies indicating that chemical dependency treatment assists low-income patients in moving toward self-sufficiency.

More than 60% of Adult Patients Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.

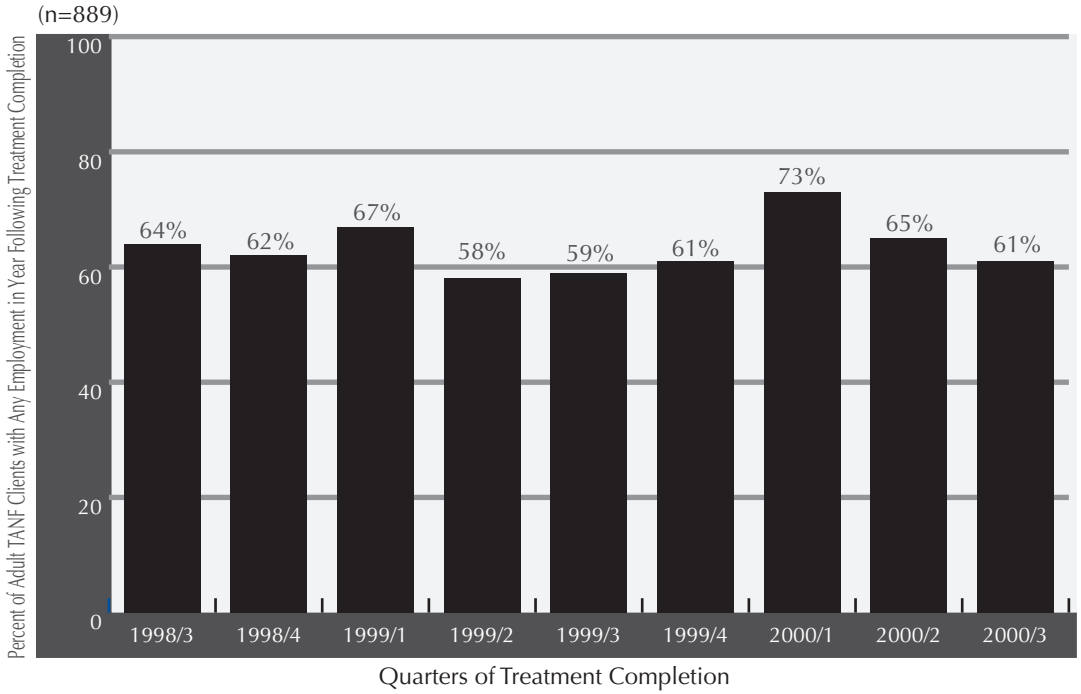


Source: Washington State Department of Social and Health Services, Research and Data Analysis (October 2001)

This graph indicates that more than 3 out of 5 adult low-income patients who completed chemical dependency treatment in the fourth quarter of Fiscal 2000, and did not require further treatment, became employed in the following 12 months. Average monthly wages in the last quarter of Fiscal 2000, were approximately $1,041. More than half (62%) worked more than 20 hours a week; 63% earned wages above the Federal Poverty Level.

Approximately one-quarter (22%) of those who became employed worked more than 35 hours a week; 100% of these earned wages above the Federal Poverty Level, with an average monthly wage of $1,790.

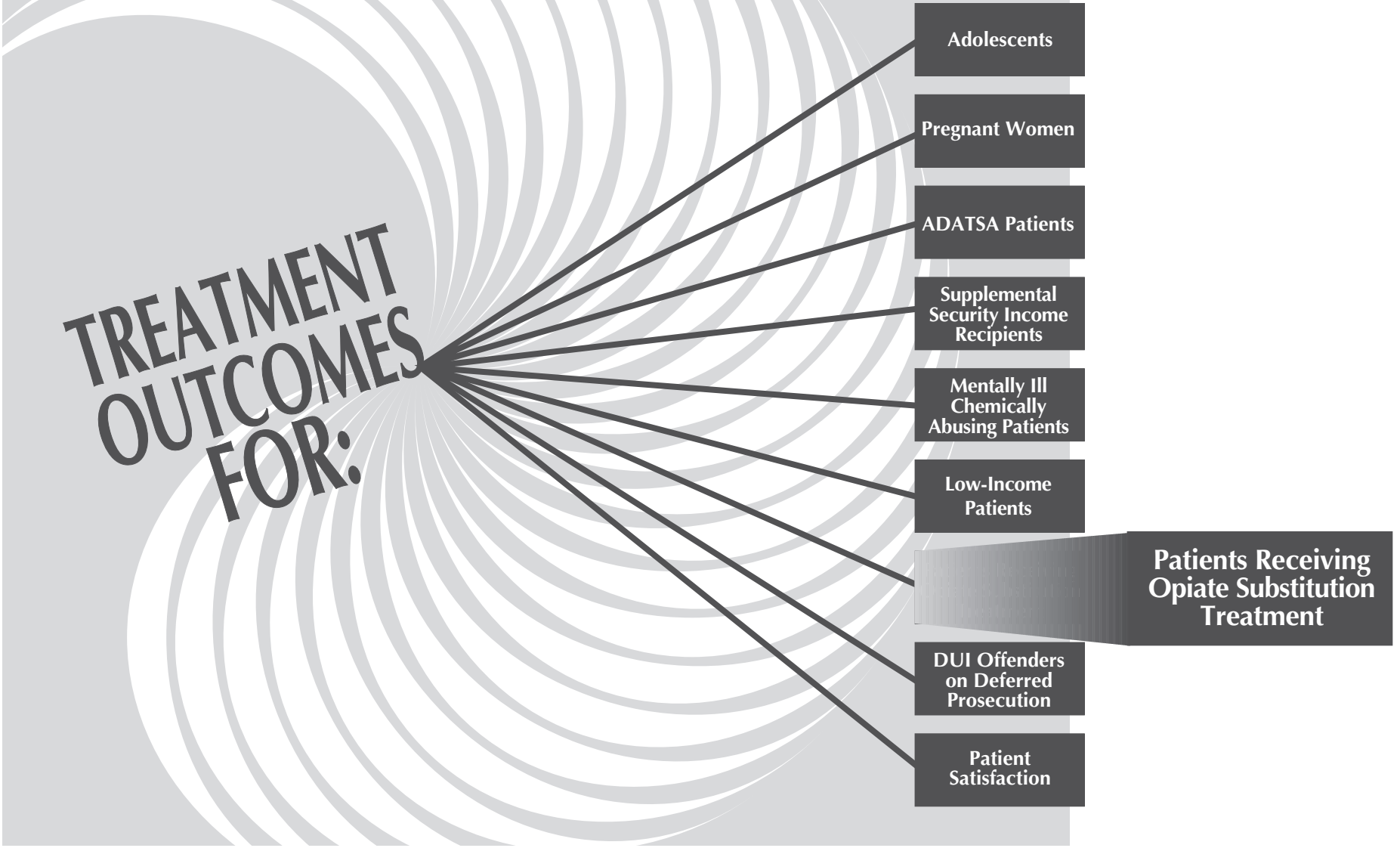
Approximately 3 out of 5 Adult Clients Enrolled in the Temporary Assistance for Needy Families (TANF) Program and Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.



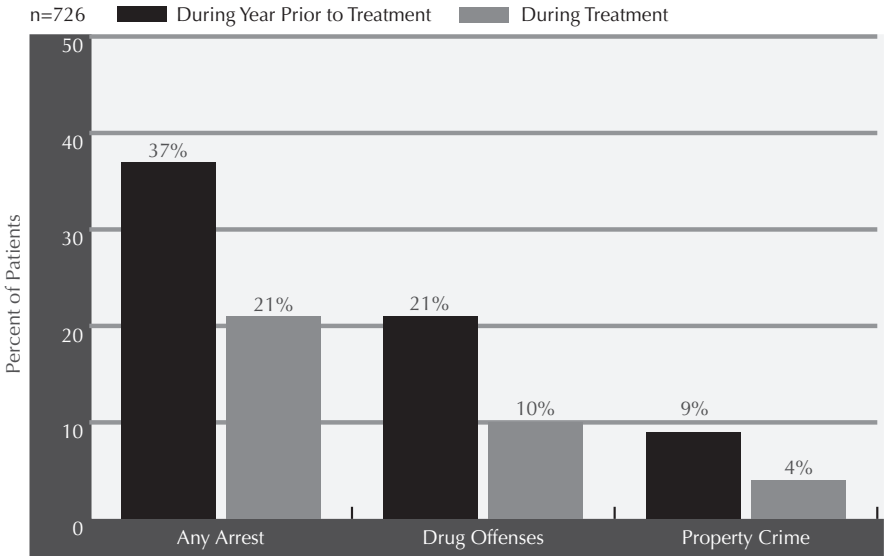
Source: Washington State Department of Social and Health Services, Research and Data Analysis (December 2001)

This graph indicates that of clients enrolled in the Temporary Assistance for Need Families (TANF) program who completed chemical dependency treatment in the third quarter of Fiscal 2000 and did not require further treatment, 61% became employed in the following 12 months. More than half (54%) worked more than 20 hours a week; 52% earned wages above the Federal Poverty Level. For TANF clients with substance abuse problems, chemical dependency treatment helps move them toward economic self-sufficiency.

Outcomes: The Benefits of Prevention & Treatment



Criminal Arrests Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



Source: Baxter, B., and Albert, D. (2001). Report to the Legislature: Determining the Value of Opiate Substitution Treatment. Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse.

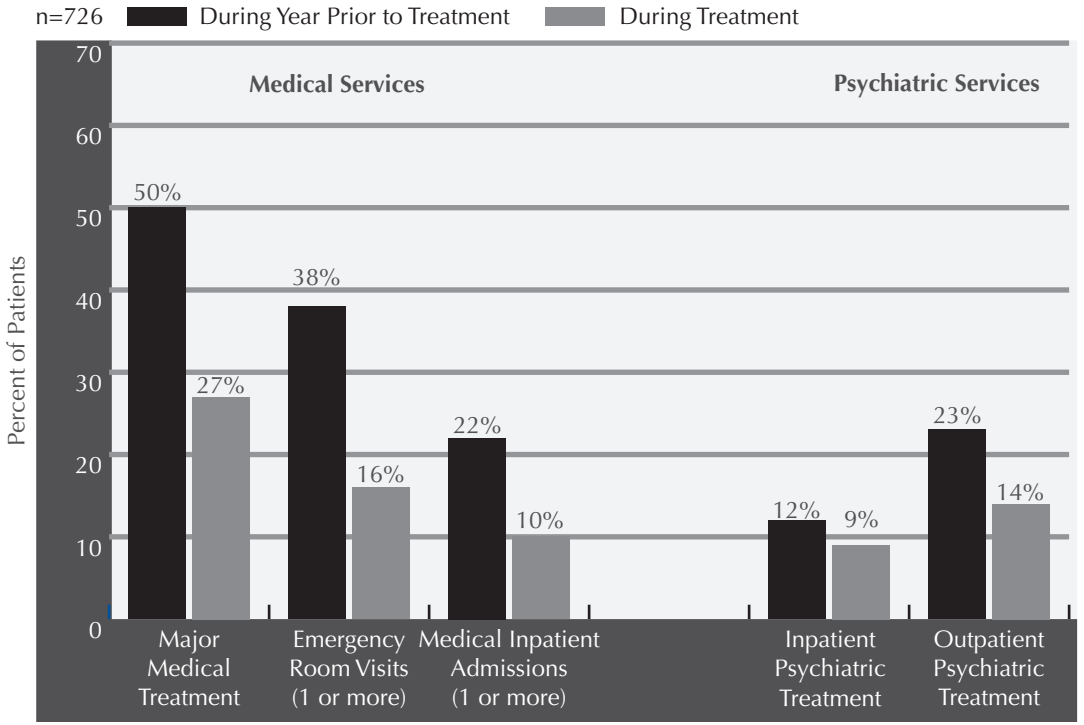
This graph indicates that patients receiving publicly funded opiate substitution treatment are less likely to be arrested for a crime during treatment than in the year prior to treatment.

It is estimated that approximately 38,000 Washington State residents have been dependent upon opiates (primarily heroin) during their lifetime.[1] Twelve opiate substitution clinics currently provide opiate substitution treatment to treat opiate addiction through administration of medication (e.g. methadone) and provision of counseling services. In addition, patients receive education, random urine drug screening to monitor drug use, and are subject to stringent rules regarding compliance. In State Fiscal Year 2001, 4,776 patients were enrolled in opiate substitution programs in Washington State, 2,870 of whom were publicly funded.

Opiate substitution treatment has scientifically been shown to work. The federal Office of National Drug Control Policy calls methadone therapy "one of the longest-established, most thoroughly evaluated forms of drug treatment."[2] A Consensus Panel convened by the National Institutes of Health in 1997 concluded, "Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity."[3]

[1] Kohlenberg, E., Yette, R., and Mack, C. (1992). Needs assessment data project report: division of alcohol and substance abuse, fiscal year 1990. Olympia, WA: Department of Social and Health Services, Office of Research and Data Analysis, 1992.
[2] Office of National Drug Control Policy (2000). The national drug control strategy: 2000 annual report. Washington, DC: Office of the White House.
[3] National Institutes of Health (1997). Effective medical treatment of heroin addiction: NIH consensus statement 1997, November 17-19, 1997 15(6).

Health Care Utilization Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



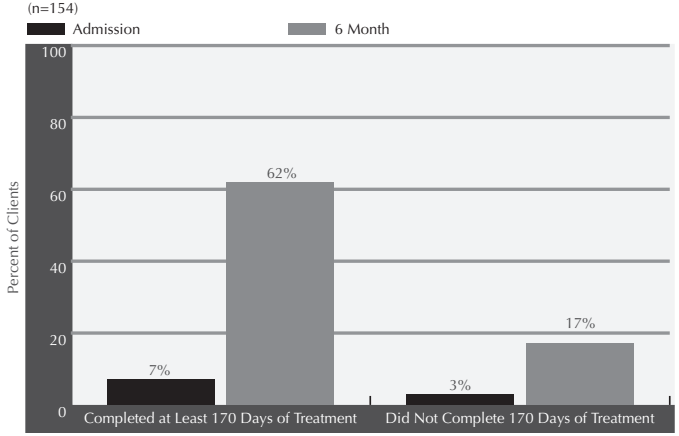
Source: Baxter, B., and Albert, D. (2001). Report to the Legislature: Determining the Value of Opiate Substitution Treatment. Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse.

This graph indicates that patients receiving publicly funded opiate substitution treatment use fewer acute health care and psychiatric services during treatment than in the year prior to treatment. This results in significant cost savings throughout the health care system.

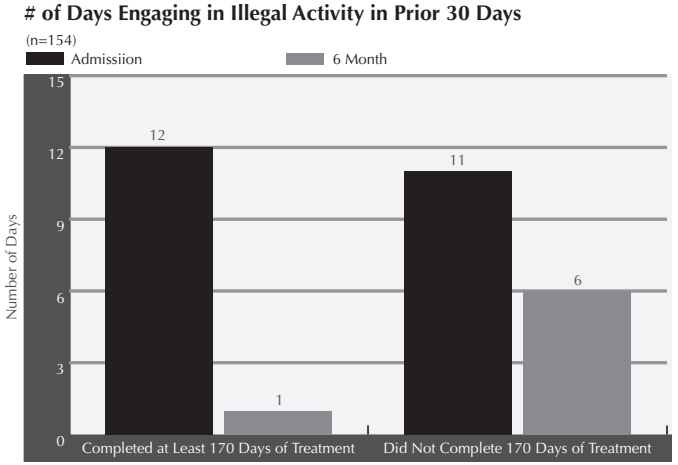
Remaining in Treatment Results in Improved Outcomes Among Patients Receiving Methadone Treatment.

A 2001 study of 154 patients admitted to methadone treatment found that at six-month follow-up, those who completed at least 170 days of treatment reported substantially higher rates of abstinence from heroin use, fewer days of illegal activity, and substantial decreases in money obtained through illegal activity.

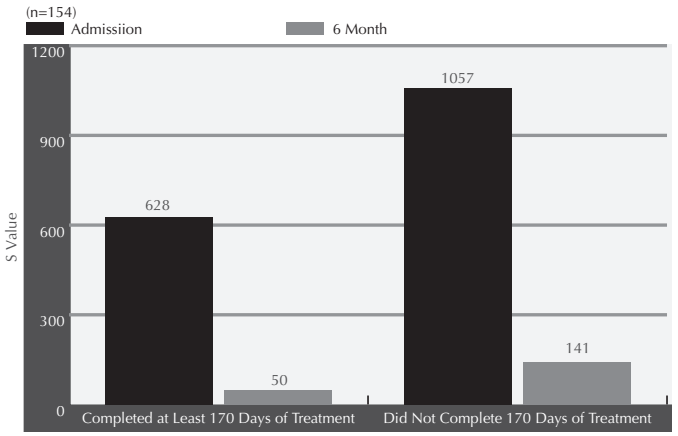
Abstinence from Heroin in Prior 30 Days



# of Days Engaging in Illegal Activity in Prior 30 Days

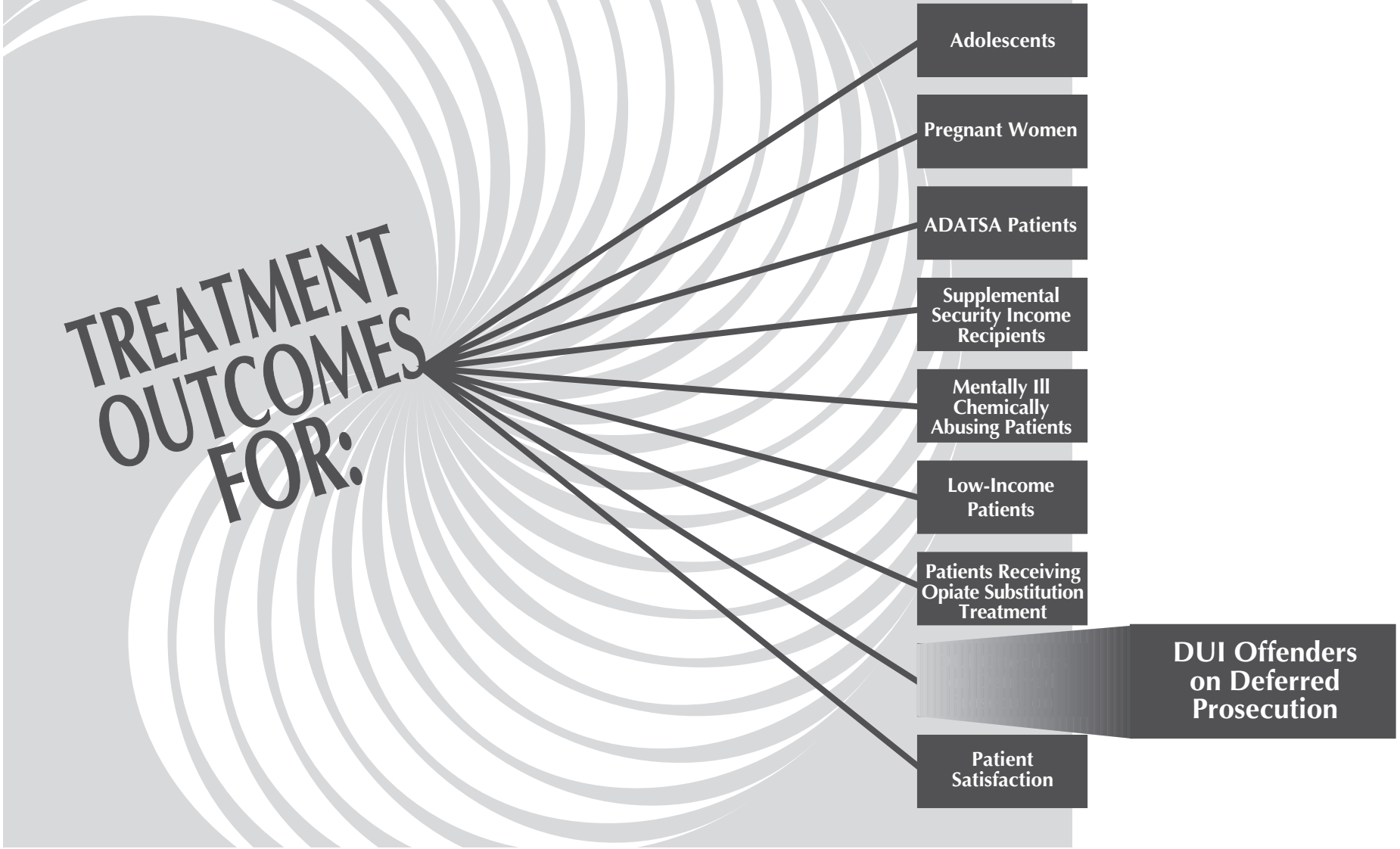


Average $ from Illegal Sources in Prior 30 Days



Source: Carney, M. (2001). Drug Use, Jail Time, and Illegal Activities Among Clients Admitted to Methadone Maintenance At Admission and 6 Months Later. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute.

Outcomes: The Benefits of Prevention & Treatment



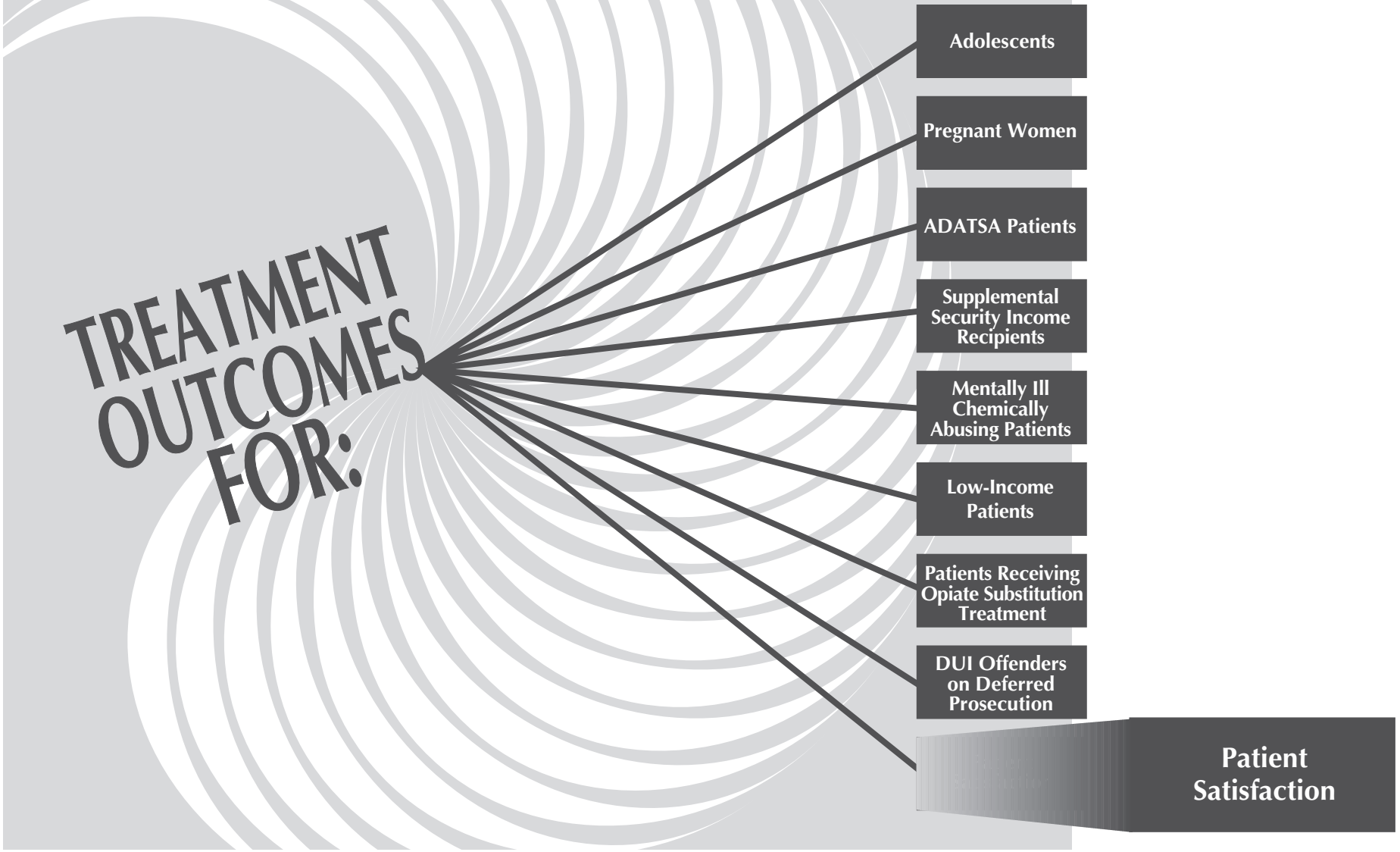
Alcoholic Convicted Drivers were More than Twice as Likely to Recidivate within Four Years After Disposition than Drivers on Deferred Prosecution.

Source: Baxter, B. L., Salzberg, P. M., & Kleyn, J. E. (1993). The Effectiveness of Deferred Prosecution in Reducing DWI Recidivism: An Update. (ADAI Technical Report 93-01.) Seattle, WA: University of Washington, Alcohol and Drug Abuse Insititute.

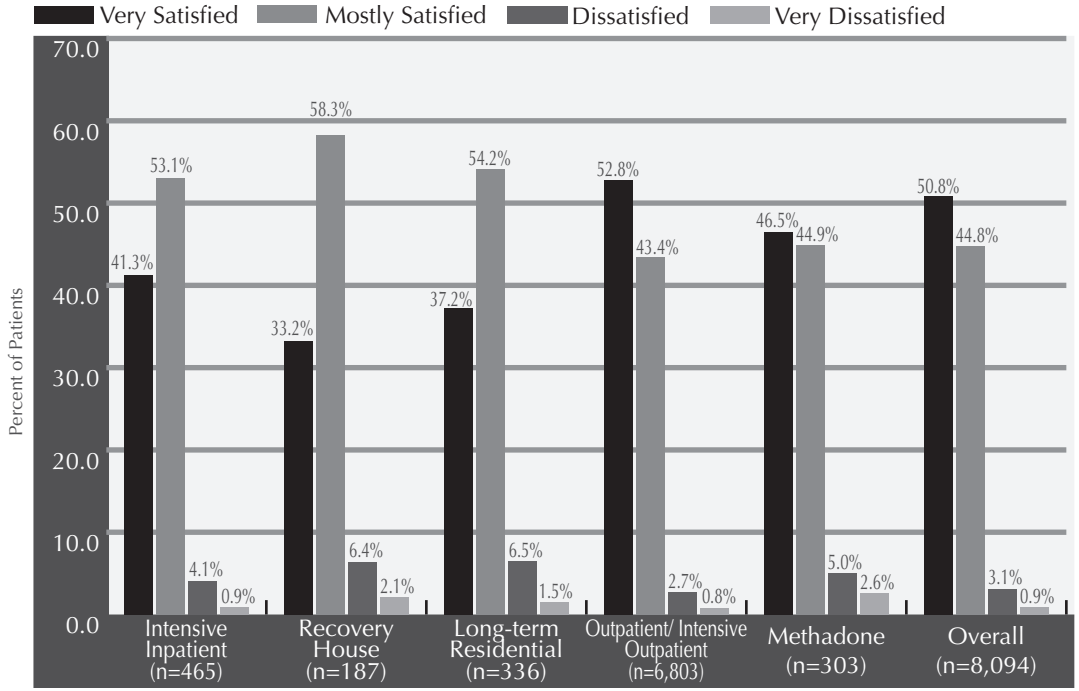
To be eligible for deferred prosecution, a person accused of Driving Under the Influence (DUI) must be diagnosed as an alcoholic and/or drug addict. They must also agree to an intensive two-year program of chemical dependency treatment where complete abstinence from alcohol and all other psychoactive drugs is required. Unlike a person convicted of a DUI, a person granted deferred prosecution is allowed to retain their driver's license. In addition, the original charge is dismissed if, during the five year deferral period, the person completes all conditions of their court order and does not commit a similar offense. The expected outcome of treatment participation is a reduction in new DUI offenses among these persons.

Findings from an evaluation conducted in 1990 suggest that deferred prosecution has had the desired effect. As the chart above illustrates, more than twice as many convicted drivers who were diagnosed as alcoholic committed an alcohol-related violation than did drivers given deferred prosecution in the four years after disposition.

Outcomes: The Benefits of Prevention & Treatment



In 2001, 96% of Patients Receiving Chemical Dependency Treatment Services Reported Overall Satisfaction with the Services They Received.



Source: Rodriquez, F. (2001). Clients Speak Out: The Statewide Client Satisfaction Survey 2001. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

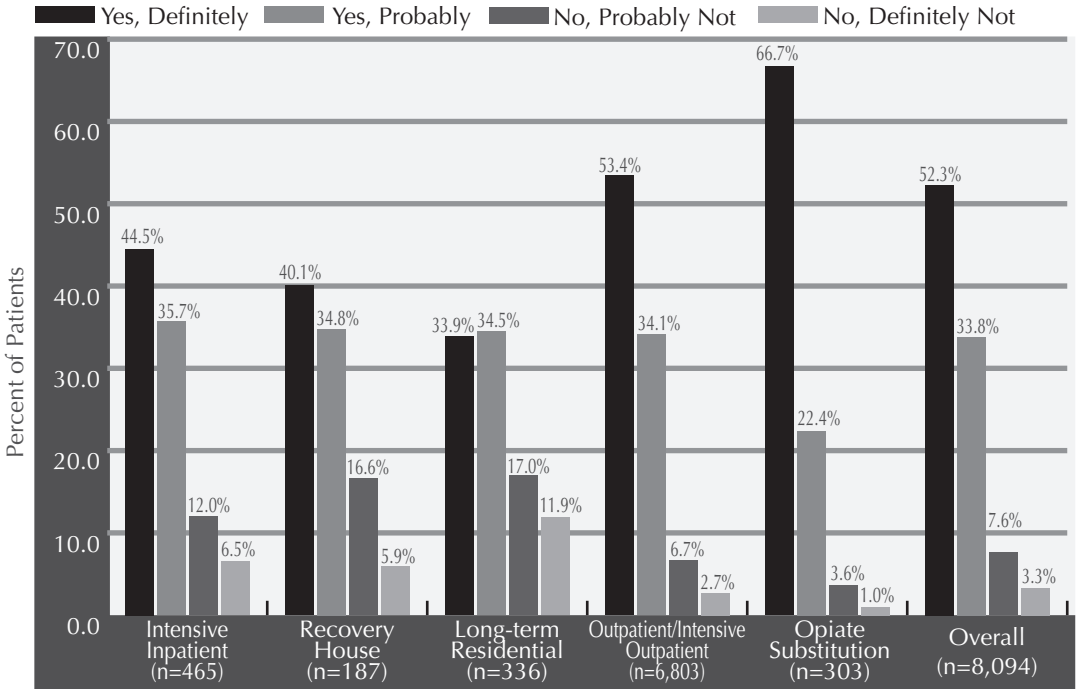
In an overall, general sense, how satisfied are you with the services you have received?

In March 2001, DASA conducted the first statewide client satisfaction survey. It was administered at 186 treatment centers to 8,094 patients, or 74% of those receiving treatment in the participating agencies during the week of the survey.

Overall, 93% of patients reported they were satisfied with the comfort and appearance of their treatment facility; 81% said they were always treated with respect by staff; 94% rated group sessions as helpful; and 86% reported they found individual counseling to be helpful.[1] Reports of responses to the survey were sent to each of the respective treatment agencies for use in quality improvement activities.

[1]Rodriquez, F. (2001). Clients speak out: The statewide client satisfaction survey 2001. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

In 2001, 86% of Patients Receiving Chemical Dependency Treatment Services Reported They Would Return to the Same Program If They Needed Help Again.



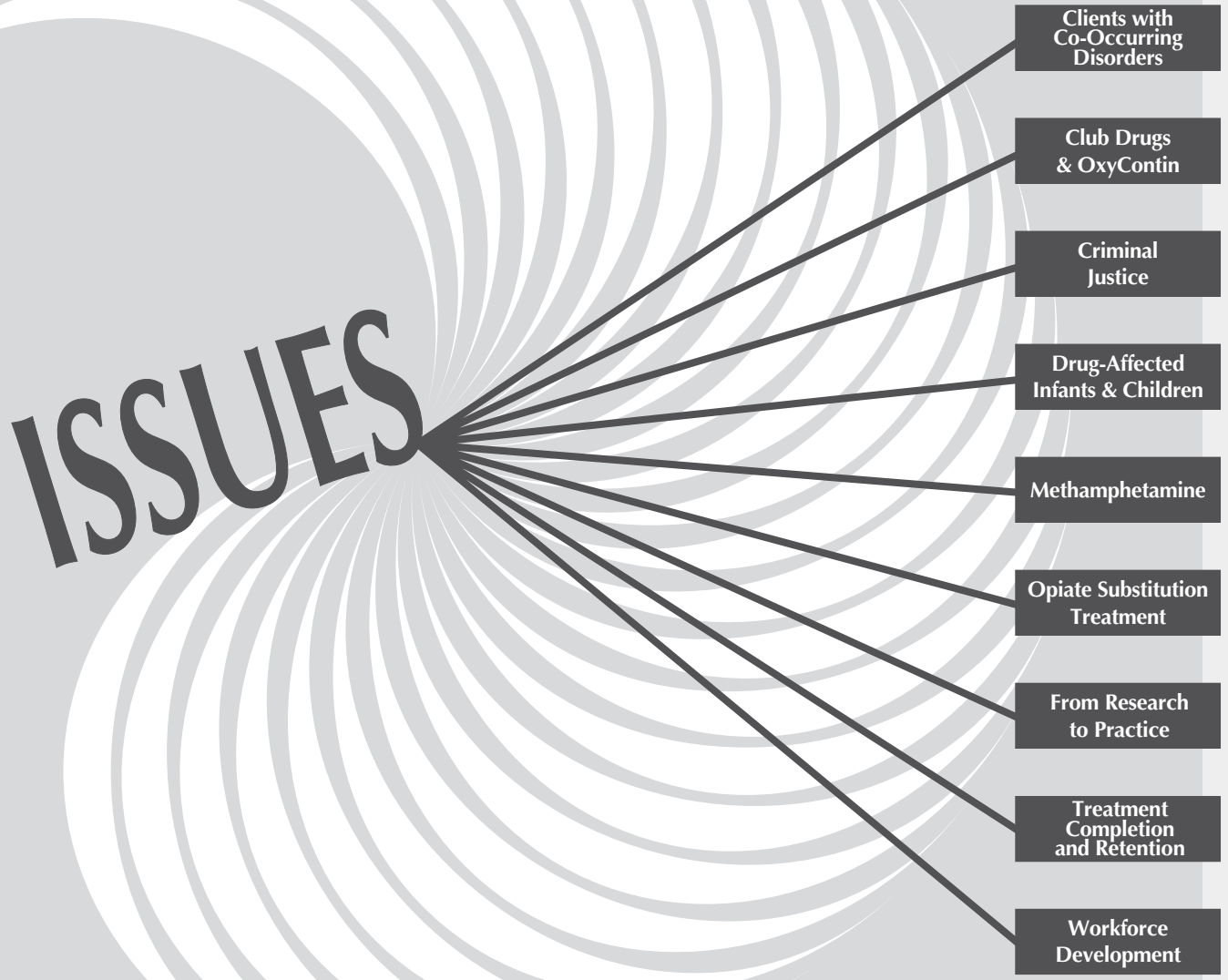
Source: Rodriquez, F. (2001). Clients Speak Out: The Statewide Client Satisfaction Survey 2001. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

If you were to seek help again, would you come back to this program?

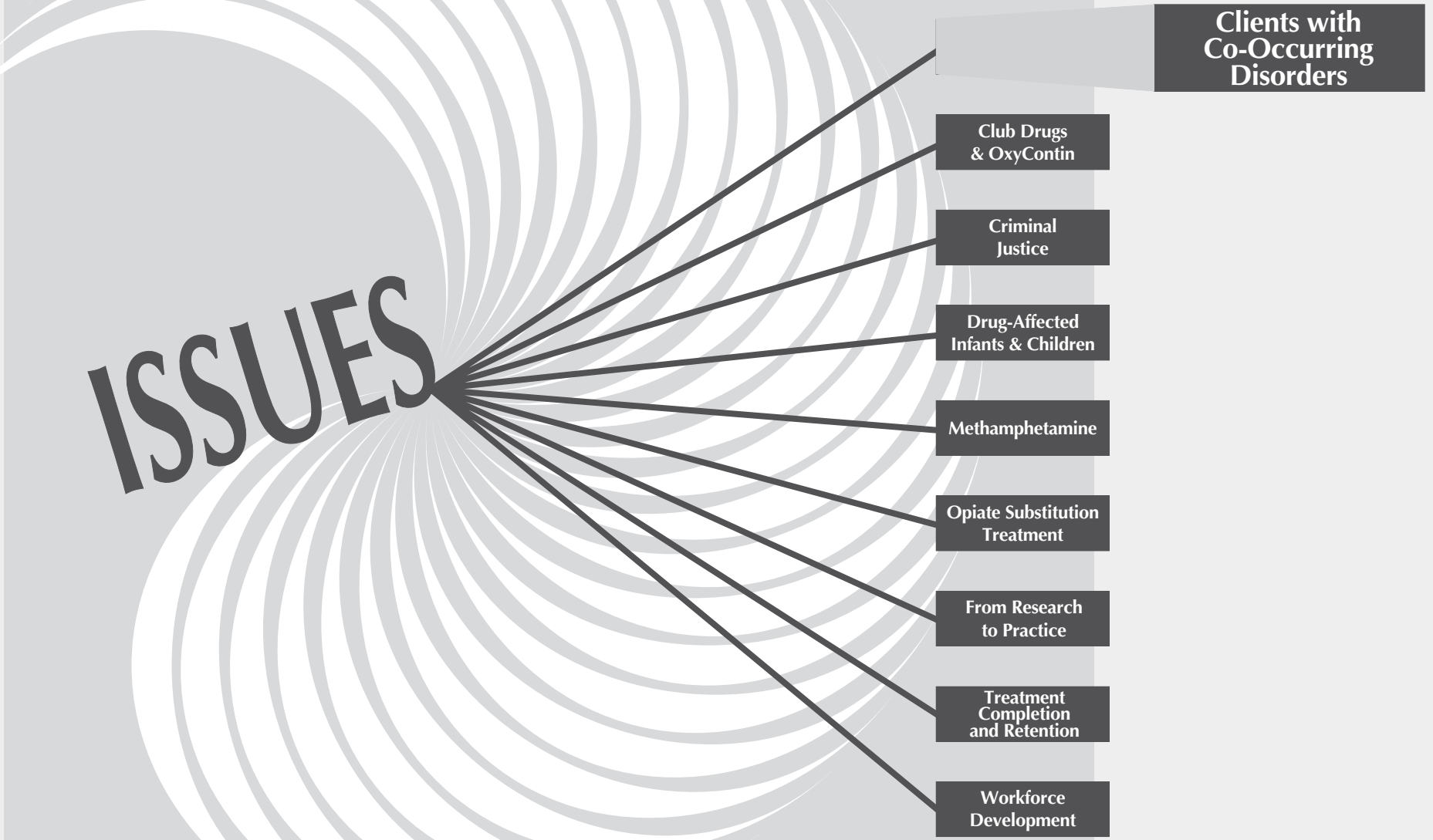
Many patients receiving chemical dependency treatment services require other services as well. Treatment agencies can play a key role in assisting patients in identifying and accessing these services. Of those reporting a need for them, 72% of patients said their treatment program was helpful in connecting them to legal services; 80% to medical services; 76% to family services; 72% to mental health services; 67% to educational or vocation services; and 56% to employment services. [1]

[1] Rodriquez, F. (2001). Clients speak out: The statewide client satisfaction survey 2001. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

The Future: Policy Issues Confronting Washington State



The Future: Policy Issues Confronting Washington State



CLIENTS WITH CO-OCCURRING PSYCHIATRIC AND SUBSTANCE-RELATED DISORDERS

The treatment of chemical dependency is both a public policy and clinical issue. Addiction contributes to many lost lives, broken families, and lost dreams. As illustrated throughout this Report, the public health and safety costs of untreated addiction are enormous. The good news is that there are effective treatment modalities that significantly improve health, reduce crime, enhance employment and earnings, and assist in avoidance of more expensive acute and long-term health-related and social costs.

There is a growing awareness that individuals may suffer from both chemical dependency and mental health disorders. When chemical dependency exists along side a co-occurring psychiatric disorder, the difficulties in providing effective treatment increase dramatically. The treatment needs of individuals with co-occurring disorders are complex, and patients often respond poorly when their disorders are treated sequentially. A major challenge is finding the most effective ways, given limited resources, to respond to these multiple needs by treating the whole individual rather than a series of symptoms. With this new awareness, has come an increased commitment to the development of collaborative relationships among state agencies, regional, and county organizations that have historically operated independently of one another.

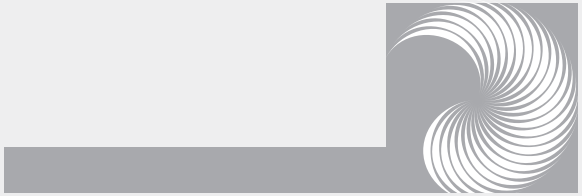
Emphasis on Training

In 1998, Division of Alcohol and Substance Abuse (DASA) and the Department of Social and Health Services, Mental Health Division (MHD) joined together to develop a 10-Step Plan for increasing collaboration between the chemical dependency and mental health treatment systems for working with patients with co-occurring disorders. Previous accomplishments of the Plan include the development of a definition of co-occurring disorders and the completion of an analysis of the barriers co-occurring clients encounter, in their attempts to access appropriate treatment.

While the majority of the 10-Step Plan's objectives have been accomplished, a significant emphasis within DASA and MHD remains the training of practitioners in the field. In the last 12 months, approximately 2,300 persons have attended training sessions on detection, diagnosis, training, and case management for persons with co-occurring disorders. In addition, the Co-Occurring Interagency Committee (CODIAC) has recently inaugurated a subcommittee that will focus upon best practices in the delivery of co-occurring disorders treatment and may have preliminary findings available for release during the Annual Co-Occurring Disorders Conference in April 2002.

There is growing concern about clients in the correctional system who jointly impact the mental health and chemical dependency systems. In response to this concern, a new CODIAC subcommittee has been formed that will look at and propose changes in procedure and policy regarding provision of services to individuals with co-occurring disorders entering and exiting Washington's jails and prisons. A concerted effort is being made to jointly train professionals who work in mental health, chemical dependency, and corrections to address the needs of the clients they have in common.

Further work remains to be done in implementing the 10-Step Plan. Needs include: setting consistent standards of care; providing fiscal incentives for the development of programs that are effective with the population affected by co-occurring disorders; and decreasing the high recidivism rate for both detoxification and psychiatric hospital admissions for this population. The chemical dependency and mental health fields, as well as policymakers, must continue to work together to remove statutory, fiscal, and philosophical barriers in order to treat this population more effectively.

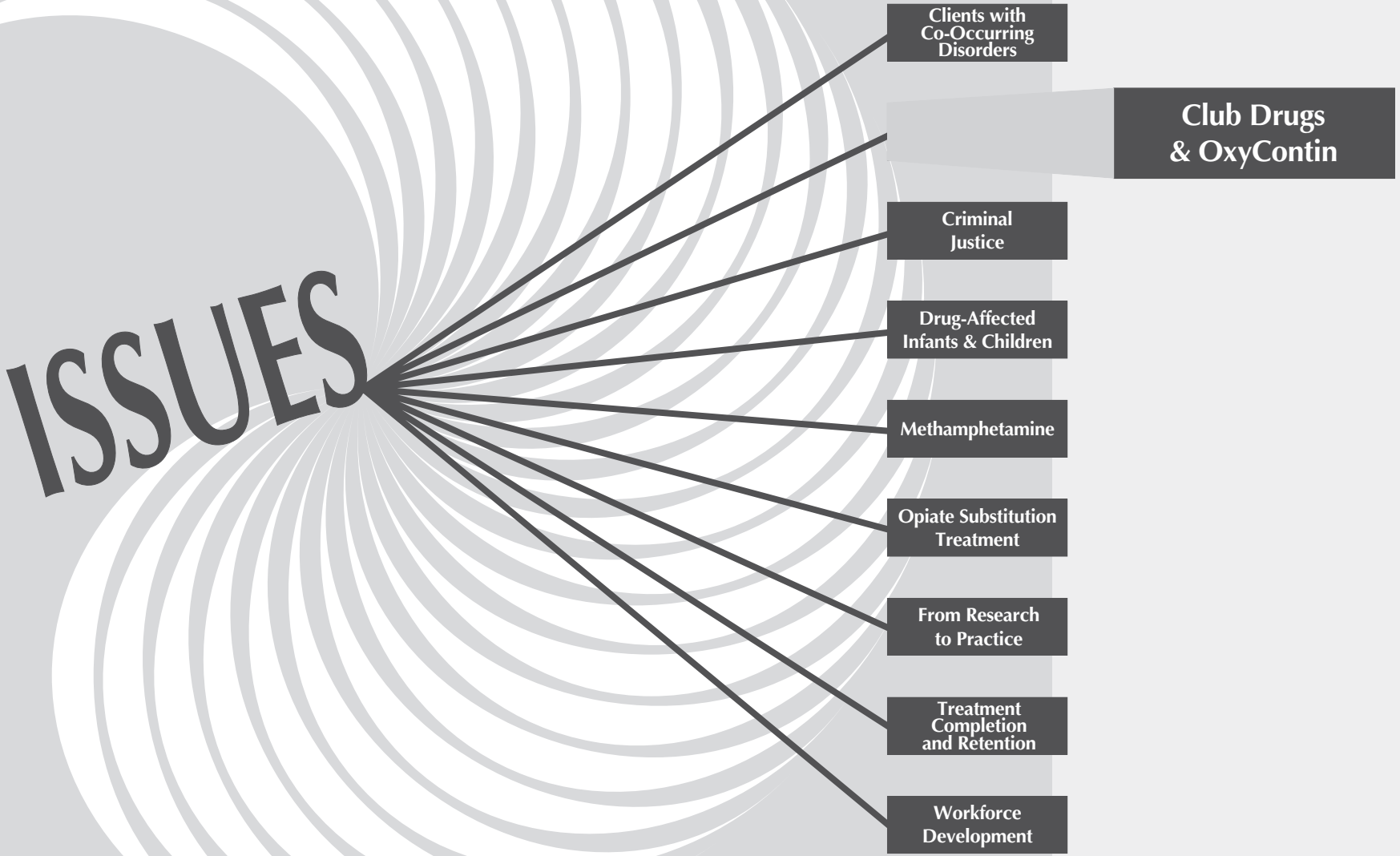


Dangerously Mentally Ill Offender Program

DASA is now involved in the second year of implementation of the "Dangerously Mentally Ill Offender (DMIO) Program." The DMIO program is a collaborative effort between DASA, MHD, and the Department of Corrections. The program was created by legislation enacted in 1999 and is intended to help improve public safety and provide additional treatment for dangerously mentally ill offenders who may also be developmentally disabled and/or chemically dependent, and who will be re-entering the community.

As of December 2001, there have been 81 persons designated as DMIO's. Of those designated, approximately 47 been released into the community. Starting at approximately three months prior to release, "wrap-around" social support services are determined and provided. These services include, but are not limited to: mental health, chemical dependency, and developmental disability services; housing; education; and medical care. A research component of the DMIO program will evaluate its long-term effectiveness in reducing criminal activity, alcohol/drug relapse, and use of inpatient hospital beds and state psychiatric hospitals.

The Future: Policy Issues Confronting Washington State



CLUB DRUGS & OXYCONTIN

The use of "club drugs" represents a relatively new trend in illicit drug use in the United States, especially in larger cites. "Club Drugs" is a general term used to refer to a group of drugs that are popular at nightclubs and all-night dance parties (known as "trances" or "raves), though it is thought they are becoming widespread in social and recreational settings as well, especially among young people. Included in this category are the hallucinogens (MDMA, LSD, PCP, Ketamine, Psilocybin), GHB and GBL, and inhalants (nitrous oxide). Methamphetamine is also popular as a club drug.[1]

Raves originated in England in the 1980's as private, underground clubs. Other areas of the world and throughout the United State now have a rave scene. Modern hip-hop dance music and techno-light shows are common features of these "rave" clubs attracting primarily young adults ages 16-25. At all-night parties in the clubs, drugs are used to improve mood, provide energy to dance throughout the night, and increase reaction to visual stimuli. The use of club drugs is seen as a way to enhance the "rave experience."

Risks Associated with Club Drug Use

There are significant health risks associated with club drug use. For example, MDMA, a methamphetamine analog, is known to cause long-term damage to the serotonin-containing neurons in the brain[2]. Serotonin neurons influence emotions, memory, sleep, pain, and other higher order cognitive processes. Therefore, it is possible that MDMA can cause a variety of behavioral consequences as well as memory impairment. [3]

Two drugs -- Rohypnol and GHB -- which are central nervous system depressants -- may be surreptitiously added to beverages without being detected, and have been associated with "date rapes". Both agents cause sedation and mild amnesia, sometimes making it difficult to use the victim's testimony effectively in rape prosecutions in criminal court. GHB at higher doses has been reported to cause an array of adverse effects from unconsciousness, seizures, severe respiratory depression, to coma and possible death.[4] The variability of adverse effects in these two drugs is highly unpredictable and can be fatal -- sometimes even on first use.

Club drugs are usually taken in multiple drug combinations, often along with alcoholic beverages, resulting in increased toxicity. GHB or Rohypnol, when added to alcoholic beverages, can lead to significant intensification of depression and possible coma due to synergistic mechanisms between the two substances. More than 75-80% of substance abusers experiment with combinations of two to three different club drugs to further enhance hallucinogenic effects.[5]

Most club drugs enter the U.S. from Europe. However, many of these drugs are produced domestically by "kitchen chemists" using common household chemicals.[6] Home recipes are readily accessible on Internet sites. Unknown pharmacological agents and other contaminants pose significant risk factors and make it difficult to determine toxicity. Thus, club drugs may consist of dangerous combinations of ingredients. Not only does this lead to a greater risk of adverse effects and potential for overdose, but also lack of knowledge regarding which drug was ingested can complicate rescue efforts. Nationally, MDMA-related emergency room incidents alone increased from 253 in 1994 to 4,511 in 2000, representing an 18-fold increase.

Club Drugs in Washington State

It is difficult to measure the prevalence of club drug use. The time period during which the drug can be identified through drug screening is very short, making it difficult to detect them through standard drug testing protocols. Most of these drugs are lacking in color, odor, and taste, and are used in combination with each other or with other drugs. Traditional emergency department indicators, treatment admissions, and identifiable emergency calls to police and poison center calls related to these drugs are extremely low. Club drugs appear in relatively few instances of drug-related deaths, and are usually incidental to the primary cause of death.

However, reports of club drug use associated with acute episodes now show up on a regular basis in Washington State,

especially in Seattle. Since 1990, there has been an increase in the number of sexual assaults, overdoses, and death-related incidences associated with club drugs. [7, 8] MDMA, GHB, Rohypnol, and Ketamine are among the synthetic drugs currently seen in Seattle.[9] In 2000, seven deaths were recorded by the King County Medical Examiner involving MDMA, with the majority involving other drugs as well.[10].

The challenges of dealing with club drugs are daunting. Law enforcement officials report frustration related to club drugs because teens perceive these drugs as harmless.[11] Compared to other addictive but expensive drugs, such as cocaine, the low monetary costs associated with club drugs may lead young adults into thinking they have found a risk-free substance. Researchers continue to study club drugs in order to develop treatment and prevention protocols. However, the risks associated with drug experimentation often lead to unpredictable and unknown results. It will require renewed partnerships among law enforcement, substance abuse prevention and treatment professionals, educators, and public and private agencies to counter these new threats to youth and our communities.

OxyContin

According to reports from the federal Center for Substance Abuse Treatment, abuse of the semi-synthetic opioid OxyContin in increasing rapidly. OxyContin is a prescription, time-release medication designed to be taken orally, and used in the treatment of pain related to cancer and other debilitating conditions. OxyContin's major benefit is that generally it only has to be taken twice a day, and because its time-release formulation, many patients suffer fewer side effects from its use relative to other analgesic narcotic medications.

Most people who take OxyContin as prescribed do not become addicted. However, abusers often crush the tablet and either snort it or dilute it in water and inject it. Crushing or diluting OxyContin disarms the time-release action and causes a powerful euphoria, similar to heroin. This has made the drug popular to the heroin-abusing population, and those who become addicted to OxyContin may begin to use heroin when Oxycontin is unavailable. Because of its time-release formulation, OxyContin contains 2-30 times the amount of the active ingredient *oxycodone* than is found in other painkillers such as Percodan and Tylox.

OxyContin in Washington State

Washington State has not been immune to the upsurge in OxyContin abuse. Emergency Department mentions of OxyContin rose from 57 in State Fiscal Year (SFY) 1999, to 124 in SFY 2000, representing a 118% increase. There have also been significant increases in chemical dependency treatment admissions for non-heroin, non-methadone opiates and opioid synthetics, from 319 in SFY 1999, to 502 in SFY 2001, representing a 57% increased. Most of this growth can likely be attributed to the abuse of OxyContin.

The Department of Social and Health Services, Medical Assistance Administration, through its Therapuetic Consultation Service (TCS), is currently tracking the use of all brand name drugs, including OxyContin, among clients receiving Medicaid drug benefits. TCS is designed to better manage drug utilization, safeguard client safety, identify clients who access multiple providers for the same prescription, and help control rising health care costs related to pharmaceutical use.

[1] Information on each of these substances, their trade and street names, and their effects are to be found at the front of this Report.
[2] McDowell, D. (1999). MDMA, Ketamine, GHB and the "Club Drug" scene [treatment]. In: Galanter, M., & Kleber, H (eds.) Textbook of substance abuse treatment, second edition, pp. 295-305. Washington, DC: American Psychiatric Press, Inc.
[3] National Institute on Drug Abuse. (2000). www.nida.nih.gov
[4] King 5 News. State moves to make "date rape" drug illegal. August 21, 2000.
[5] McDowell, D. (1999). MDMA, ketamine, GHB and the "Club Drug" scene [treatment]. In: Galanter, M., & Kleber, H (eds.) Textbook of substance abuse treatment, second edition, pp. 295-305. Washington, DC: American Psychiatric Press, Inc.
National Institute on Drug Abuse. (2000). NIDA conference highlights scientific findings on MDMA/Ecstasy. NIDA Notes 16(5) (December 2001), 1.
[6] National Institute on Drug Abuse. (2000). www.nida.nih.gov
[7] De Young, K. Ecstasy influx is an enforcement problem. The Washington Post: August 2, 2000.
[8] Bartley, N. Overdoses of 'gray-market' drug GHB on the rise. Seattle Times- south bureau. November 27, 2000.
[9] United States Department of Justice, Drug Enforcement Administration
[10] Community Epidemiology Work Group. (June 2001) Recent drug abuse trends in the Seattle-King County area, 9. Bethesda, MD: National Institutes of Health, National Institute on Drug Abuse.
[11] Bartley, N. Overdoses of 'gray-market' drug GHB on the rise. Seattle Times - south bureau. November 27, 2000.
Office of Applied Studies. (2001). Year-end 2000 emergency room department data form the Drug Abuse Warning Network. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

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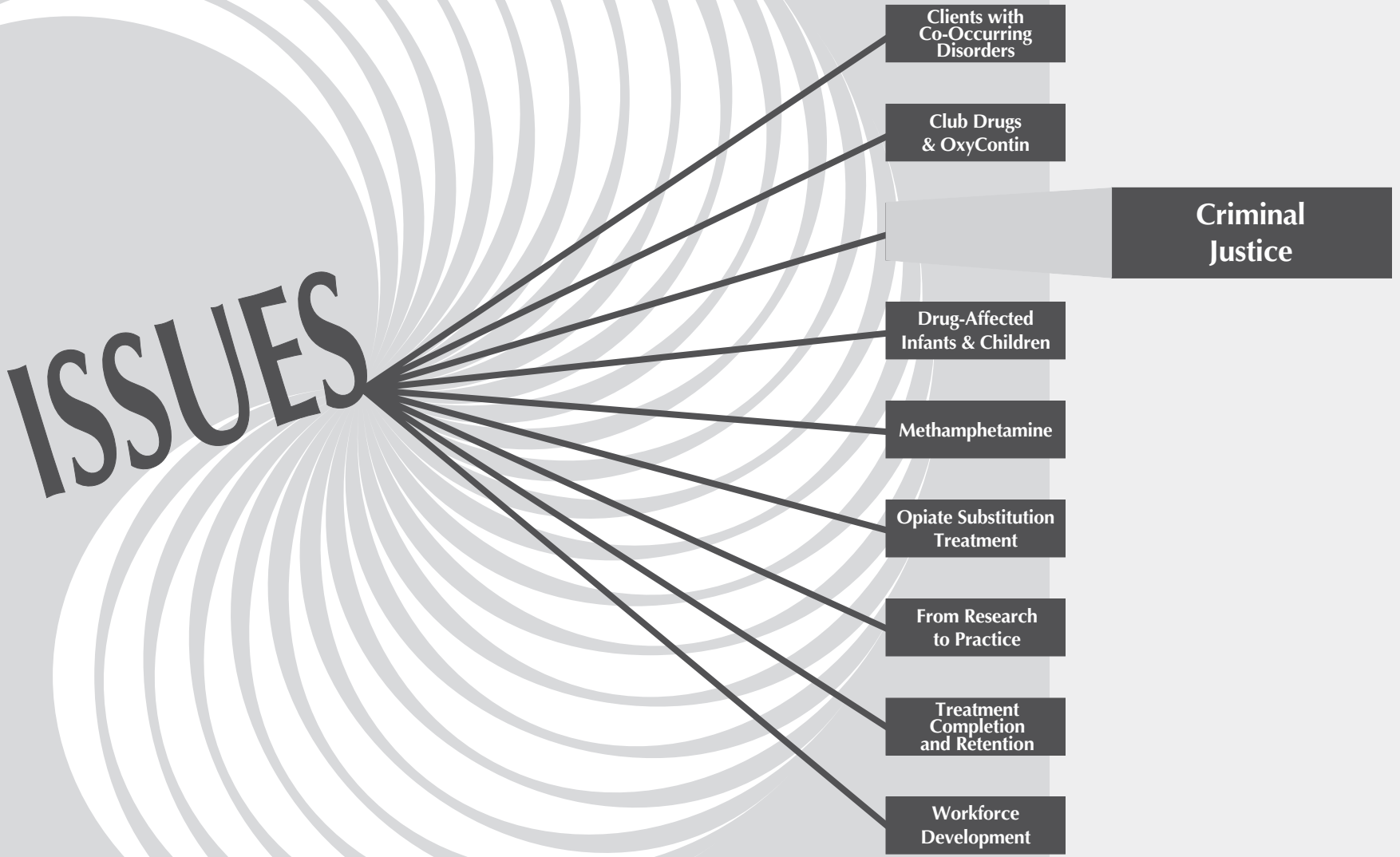

Criminal Justice

During the last two decades, both the U.S. and Washington State have experienced a huge increase in the number of drug offense cases, coupled with increasingly harsh state and federal penalties for drug possession and distribution. This has contributed significantly to the taxing of already overcrowded courts, jails, and prisons. It addition, there were substantial increases in the number of drug-abusing offenders serving time for other crimes.

Since the implementation of the Sentencing Reform Act in Washington in 1984, the Legislature has made sentencing changes during virtually every session. One of the impacts of these changes has been a doubling of the prison population over the last decade. The number of drug offenders in prison increased 250% since 1989, rising from 912 offenders to 3,174.[1] Of the 15,306 adult prisoners in state prisons in FY 2001, 20.7% were drug offenders.[2] Drug offenders are not the only prisoners who need treatment. The Department of Corrections estimates that 60-80% of prisoners are in need of chemical dependency treatment, but only about 18% of prisoners received treatment in FY 2001.[3] Without appropriate treatment, offenders are more likely to re-offend and return to prison. The costs of incarceration, and the costs of servicing the debt associated with the capital expansion needed to create beds for these offenders has gone from $19 million per year in 1989 to $89 million per year in 2001. The estimated State General Fund impact from the increased drug offender population from 1990-2001 has been over $653 million for operating budget impact, and over $181 million for the capital budget.

It has become increasingly clear to criminal justice personnel and policymakers that the traditional means of adjudicating and punishing non-violent drug-abusing offenders, while expensive, has not worked effectively. It has not resulted either in reducing criminal recidivism, curtailing drug use, or enhancing public safety.

Drug Offender Sentencing Reform

As the costs of incarcerating drug offenders have risen, there has been a growing awareness of the effectiveness of drug treatment in reducing re-offense and saving money. A 2002 study of publicly funded treatment examined arrest records before and after treatment indicated:

- A 21% decline in the number of clients arrested following treatment;
- A 33% decline in the number of arrests for felony offenses following treatment;
- Reduced risk of felony arrests for clients that complete treatment and for those with longer stays. [4]

A review of all drug treatment evaluation studies in the United States undertaken by the Washington Institute for Public Policy concluded drug treatment programs save substantially more then they cost. Drug courts, in particular, save almost three dollars for every dollar of taxpayer costs when victim costs are factored in. Felony recidivism rates are reduced from 43.2% without drug courts, to 39.5%, representing a decrease of about 8%.[5] Providing treatment to drug offenders benefits the offenders, the criminal justice system, taxpayers, and communities.

With bipartisan support, 2SHB 2338 – The Drug Offender Sentencing Reform Act -- was passed in the 2002 Legislative Session. Key provisions of the bill include:

- Establishing a Criminal Justice Treatment Account (CJTA) funded out of savings to the Department of Corrections by reducing sentences for certain drug offenders;
- Utilizing savings for treatment and limited treatment support services;

- Establishing workgroups to develop:

  A methodology for calculating the savings;

  Formulas and grant processes for distribution of funds to counties; and,

  County plans for submission to the formula and grant panels.

- Establishing a new drug sentencing grid and a review committee.
- Setting minimum standards for the participation of offenders in drug courts;
- Authorizing studies of the effectiveness of the new sentencing grid and drug courts.

In State Fiscal Year 2005, the amount available for treatment and support services is currently estimated to be $8.25 and will serve more than 2,000 individuals in community-based treatment, as well as drug-addicted offenders in prisons.

Drug Courts

The basic strategy behind drug courts is to use the power of the criminal justice system to force offenders who are addicted to illicit drugs and/or alcohol to undergo substance abuse treatment. By treating the disease of addiction, criminal recidivism and the social and economic costs associates with drug use, as well as crime and corrections costs, can be reduced

The first drug courts started operating in Washington State in 1994. Adult drug courts currently operate in 12 counties: Clallam, Clark, Cowlitz, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, and Yakima. A thirteenth drug court is in the planning stages for Mason County. There are also four youth drug courts and three tribal courts.

Drug courts will be a primary mechanism of providing supervised treatment under 2SHB 2338. The legislation also calls for an evaluation of the cost-effectiveness of existing drug courts and their impacts on reducing recidivism by March 1, 2003.

Chemical Dependency Disposition Alternative (CDDA)

The CDDA program provides local juvenile courts with a sentencing option for chemically dependent youth, allowing judges to order youth into treatment instead of confinement. Enabling legislation was enacted in 1998. The program represents a collaboration between the Juvenile Rehabilitation Administration, Medical Assistance Administration, DASA, local juvenile courts, University of Washington, and county alcohol/drug coordinators. Annual reports are provided to the Legislature on the effectiveness of CDDA programs. During State Fiscal Year 2001, 537 youth received treatment through CDDA

ESSB 6535, passed during the 2002 Legislative Session is intended to increase the numbers of youth eligible for CDDA. It would do so by permitting the courts to adjust the crime level of the charges upward, and then suspend the sentence so that a juvenile offender can be ordered to complete a full course of treatment under CDDA.

New Initiatives

There are several new initiatives underway to deal with the complex needs of juveniles who have come into contact with the criminal justice system. A new program in Seattle-King County – Reclaiming Futures – seeks to work toward long-term, countywide system reforms. The goals of Reclaiming Futures are to:

- Design and implement an effective continuum of assessment, treatment, and supports for every child with a substance abuse problem adjudicated through local courts;
- Provide supports for substance-abusing youth and youth with co-occurring disorders beyond their court and treatment system participation; and
- Redirect and invest both current and future funding for these youth based upon their needs, the success of the model, and the will of the community.

Reclaiming Futures is targeting 100 youth offenders who are substance abuses and/or dually diagnosed and their families per year. A comprehensive blended justice and treatment approach will ensure linkages and coordination of services which are culturally competent and directed at the unique needs of each youth and family. A full-scale evaluation is planning with the assistance of the Robert Wood Johnson Foundation.

[1] From a March 12, 2002 Presentation by Washington State Senate Committee Services Staff.
[2] Adult Corrections Caseload Forecast. Caseload Forecast Council. November 2001.
[3] DOC CD Program Overview March 2001
[4] DSHS Research & Data Analysis Division Fact Sheet 4.42. March 2002
[5] Washington State Institute for Public Policy. (May 2001). The comparative costs and benefits of programs to reduce crime, 23-26. Olympia, WA.

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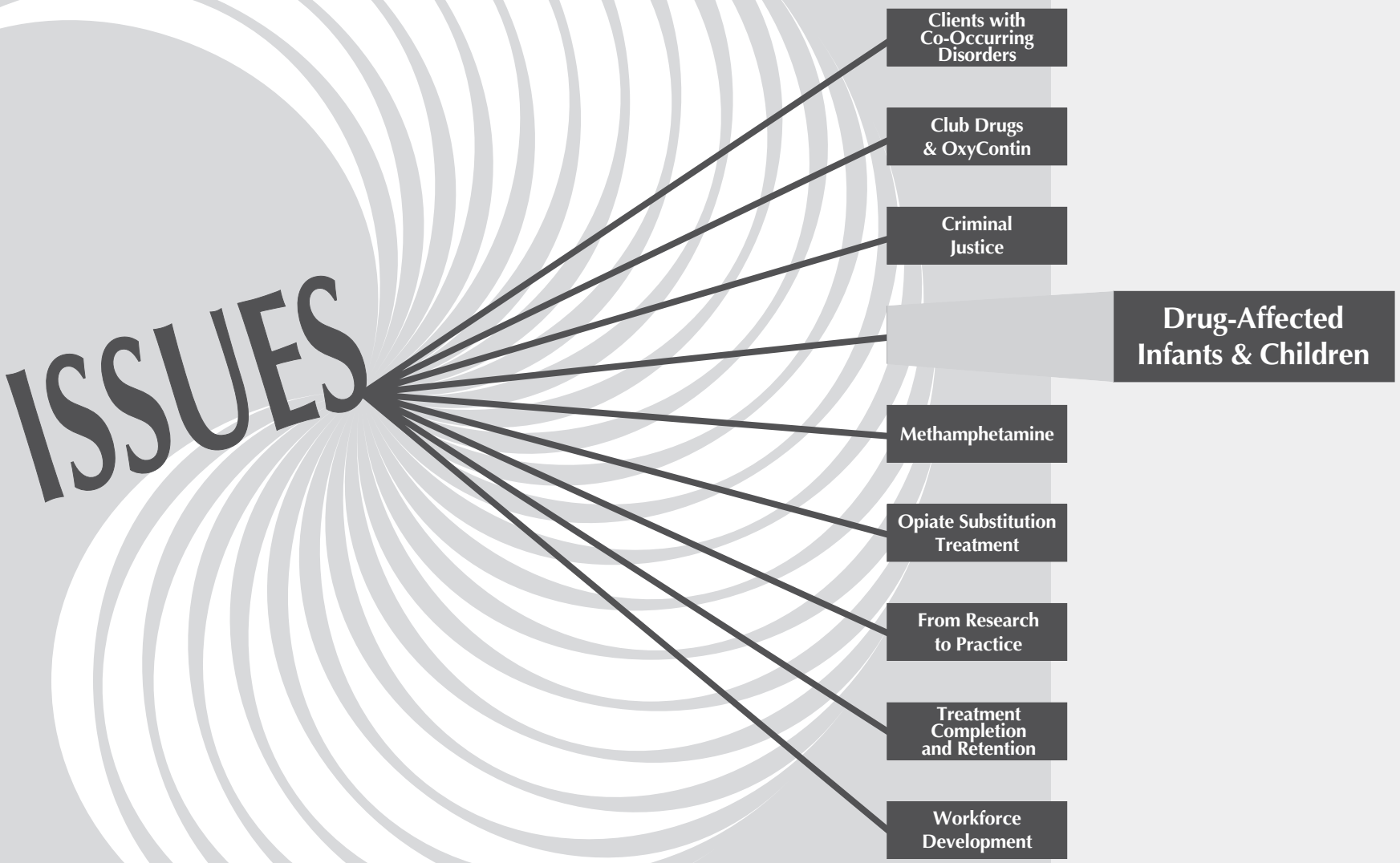


DRUG-AFFECTED INFANTS AND CHILDREN

Over the years, the Division of Alcohol and Substance Abuse has striven to educate key stakeholders regarding the nature of addiction and the recovery process, and promote understanding of alcohol and drug use by pregnant and parenting women as a public health issue. Substance abuse during pregnancy is a serious problem, as it puts both mother and child at risk. A 1997 report by the Department of Social and Health Services (DSHS), Research and Data Analysis (RDA), estimates that 8,000-10,000 infants each year are born to women in Washington who use alcohol or other drugs during pregnancy. Approximately 800-1,000 infants are born with measurable effects that can be attributed to substance abuse during pregnancy.[1] Other effects may manifest themselves later in a child's development.

Substance abuse is also a significant contributing factor to the incidence of child abuse and neglect. DSHS' Office of Children's Administration Research found substance abuse was involved in 49% of reported child abuse incidents.[2] Due to the insufficient number of homes in which to place these children, chemical dependency treatment services and child protection service agencies are seeking strategic ways to more effectively engage abusive parents in treatment. Substance abuse treatment is necessary to improve the health and welfare of children and maintain family units. Many of these families are impoverished and experience complex problems, increasing the challenge for service providers. Placing chemical dependency counselors in local Child Protective Services' offices to provide outreach services, and developing sites where families can receive several services under one roof are two innovative responses to this crisis.

As required under HB 3103 enacted in 1998, the Department of Health (DOH) has developed "Guidelines for Screening for Substance Abuse During Pregnancy" (June 1999). DOH continues to train physicians throughout Washington State to assist them in identifying pregnant and lactating women at risk of producing a drug-affected baby.

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) Services

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) are the leading known causes of mental retardation, and are entirely preventable. FAS/FAE are both national and state problems that impact children, families, and communities. In 1995, the Washington State Legislature unanimously adopted legislation directing DSHS, Office of the Superintendent of Public Instruction, DOH, and Department of Corrections to execute an agreement to ensure the coordination of programs serving children who have FAS/FAE, and women at high risk for having children with FAS/FAE. The legislation also provided for family advocacy groups to participate in the planning, development, delivery, and review of services available to FAS/FAE children and families.

Since 1995, the Division of Alcohol and Substance Abuse (DASA) has voluntarily served as program chair of the Fetal Alcohol Syndrome Interagency Work Group to ensure continued development and implementation of services targeted at identification, prevention, and intervention with individuals and families suffering from FAS/FAE. The FAS Family Resource Institute is a grassroots non-profit organization of parents working together with professionals to identify, understand, and care for individuals and families affected with FAS/FAE. The FAS Diagnostic and Prevention Network consist of seven clinical sites statewide under the auspices of the University of Washington, providing a broad range of screening, diagnostic, education, training, and referral services.

Parent-Child Assistance Program (P-CAP)

A prime opportunity to intervene with substance-abusing women is during pregnancy. Early intervention during the prenatal period increases the likelihood a woman will successfully recover from her substance abuse and that babies

will be born drug-free and with health uncompromised by the mother's alcohol or drug abuse.[3]

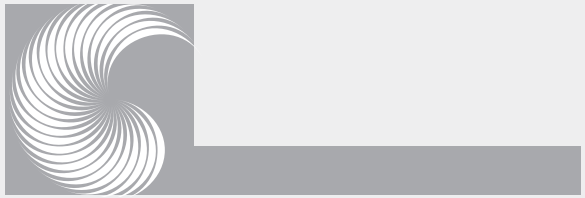
DASA's Parent-Child Assistance Program (P-CAP) provides referral, support, and advocacy services to approximately 360 high-risk substance abusing pregnant and parenting women and their young children annual in King, Pierce, Spokane, Grant, and Yakima Counties. Services include referral for substance abuse treatment and continuing care, assistance in accessing local resources for family planning, safe housing, health care, domestic violence service, parenting skills training, child welfare, child care, transportation, and legal services. Advocates work with clients to ensure necessary services are delivered in a timely manner. Collaborative relationships include liaison with courts, schools, vocational centers, therapeutic childcare centers, and the statewide Fetal Alcohol Syndrome Diagnostic and Prevention Network established by the University of Washington.

Such programs include assertive outreach to engage and treat women prior to the development of problems such as loss of child custody, and case management to coordinate the delivery of wrap-around services. Additional challenges include coordinating treatment with prenatal and other medical appointments, providing childcare for infants and older children, and offering parenting support and training.

Comprehensive Program Evaluation Project (CPEP) - Safe Babies, Safe Moms

Comprehensive programs addressing multiple treatment needs have demonstrated effectiveness in working with families and children affected by substance abuse. DASA has formed a state-level consortium with Research and Data Analysis, Economic Services Administration, Medical Assistance Administration, and Children's Administration within DSHS, and DOH to respond to the disturbing number of births of alcohol- and drug-affected infants. Three pilot program sites, in Snohomish, Benton-Franklin, and Whatcom Counties, have been established to work with 250 high-risk substance-abusing pregnant and parenting women and their children. A specialized Targeted Intensive Case Management (TICM) multidisciplinary team serves each site. TICM provides assertive outreach and engagement, linkages to necessary services including chemical dependency and mental health treatment, family planning, parent education and support, therapeutic childcare, and early childhood intervention and development services. A continuum of chemical dependency services is provided with an emphasis on enhanced long-term residential treatment, up to 18 months of transitional housing, and other safe and alcohol/drug-free housing options. Length of involvement in both residential and outpatient chemical dependency treatment has been shown to be associated with better birth outcomes.[4] CPEP's goal is to stabilize women and their young children, identify and provide necessary interventions, and assist women in gaining self-confidence as they transition from public assistance to self-sufficiency.

A two-part evaluation will be undertaken. The first, completed in 2001, focused on program development and implementation issues. The second, due at the end of 2003, will evaluate mother- and child-based outcomes. The lessons that the state implementation team is learning from implementing these pilot projects are many. The findings of the first evaluation discovered that the team approach to serving clients takes a lot of work, but is a unique and essential aspect of the CPEP program. Participation in a program that requires providers to work together as they serve clients improves the working relationships among those providers. At the state and local levels, staffs are learning about the importance of using a team approach to serve clients, as well as the challenges that accompany such an approach. The teams are also learning more about the availability of essential community resources required to meet the needs of the CPEP clients. Finally, the state team is learning how to prioritize the



resources available to serve the CPEP clients and to identify some efficiencies in program operations.

Future Challenges

The efficacy of program such as P-CAP and CPEP can only be measured over the long-term, as the effects of maternal alcohol and substance abuse are spread over the lifetimes of drug-affected infants and children. In addition, comprehensive evaluations are necessary to determine the optimal mix of services to be offered to maximize impact and achieve positive outcomes. Commitments are needed to ensure continuation of programs, provide for evaluation, and to expand their reach.

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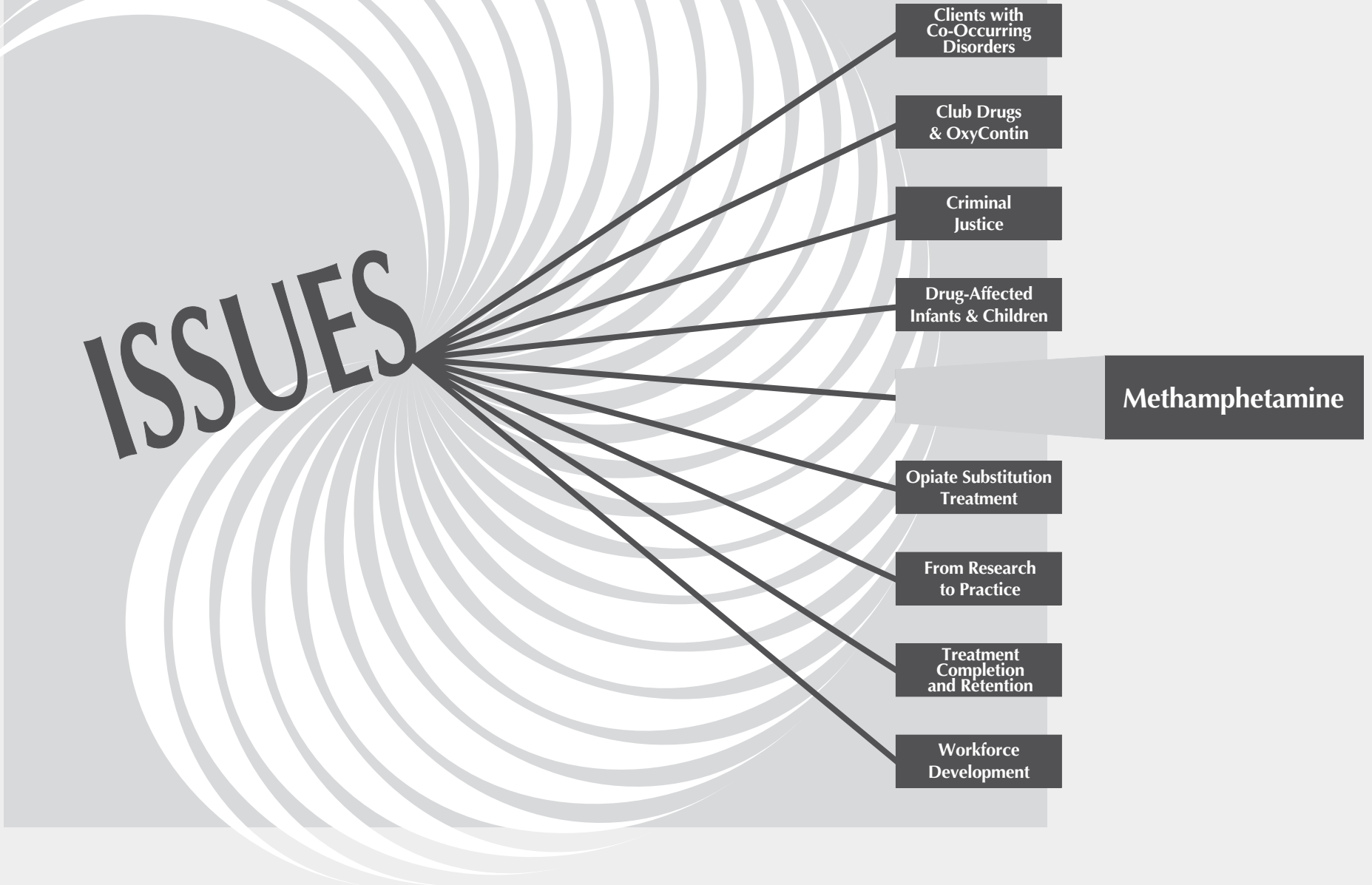


METHAMPHETAMINE

Washington State is experiencing a methamphetamine epidemic. The number of methamphetamine laboratories reported to the Department of Ecology (Ecology) rose from 38 in 1990 to 1,886 in 2001, a more than 50-fold increase.[1] Although admissions for methamphetamine are still lower than those for either alcohol and marijuana, publicly funded treatment admissions for methamphetamine more then doubled from 214 to 538 for youth, and 1,853 to 4,308 for adults from 1997 to 2001.

The impact upon public health and safety from this epidemic can be devastating. Methamphetamine use is linked to the transmission of sexually transmitted and blood-borne infections, including syphilis, HIV, and hepatitis C, through sharing of injection drug-using equipment and unprotected sexual activity. Data from King County indicates that 47% of men who have sex with men and inject methamphetamine are infected with HIV.[2]

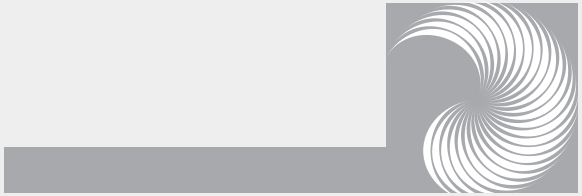
Research indicates the effects of methamphetamine use are both short- and long-term. Addiction often involves repeated and prolonged use for as long as several weeks. During this period, the user may experience feelings of aggression, tendency toward violence, anxiety, paranoia, and hallucinations. Individuals may exhibit signs of toxic psychosis, becoming belligerent and dangerous at the same time. The risk of child abuse and domestic violence is significantly increased. Prolonged exposure to relatively low levels of methamphetamine can result in long-lasting functional and molecular changes in the brain.[3]

Methamphetamine use is linked to crime. The Arrestee Drug Abuse Monitoring Program (ADAM) in Spokane County found that in 2000, 21% of males and 33.3% of females arrested tested positive for methamphetamine.[4]

Methamphetamine laboratories are found in all areas of Washington State. More than 31% (585) of the labs reported in 2001 were in Pierce County. But they are now spreading. In Benton County, 85 labs were discovered in 2001, 41 in Grays Harbor County, and 57 in Clark County. The number of labs reported in Spokane County in 2001 (248) is more than 22 times the number in 1998 (11). Statewide, the numbers of new labs reported to Ecology seem to have leveled off during the last 10 months.[5] Guarding suspected sites before and after assistance from the Washington State Patrol's Incident Response Team and its mobile lab stretches the limited policing resources of smaller jurisdictions. Four local law enforcement agencies – King County Sheriff's Office, Seattle Police Department, Pierce County Sheriff's Department, and the Tacoma Police Department – have their own methamphetamine incident response teams.

Newer methods of synthesizing methamphetamine have made it possible to produce larger quantities of a more potent drug in less time. Although active labs are typically located at rental properties, there is an increase in the numbers found in motels, state campgrounds and federal forests. In the five-year period between 1995-2000, the Washington State Department of Health received notification of 16 methamphetamine laboratories in motels. In 2001 alone, 16 labs in motels were reported. Chemical residues left behind can cause chemical burns, upper respiratory distress, and, in some instances, death. Chemical contamination resulting from methamphetamine production has been found at lab sites up to two years after they were closed down[6].

Residential methamphetamine lab cleanup crews estimate children are or have been present at 35% of the drug labs they are called to investigate.[7] It is now routine for law enforcement professionals to call in Child Protective Services to intervene on behalf of these children, who are usually removed from the home until methamphetamine-addicted parents have stabilized and are no longer using drugs.



Turning the Tide

Given its current virulence and growth, turning the tide on the methamphetamine epidemic requires significant, new and expanded cross-system collaborations at both the state and community levels. Efforts will need to focus on:

- Development and implementation of community-based prevention strategies;
- Expanded law enforcement efforts, including adequate, proactive investigative capacity at the local and regional level;
- Enhanced cleanup capabilities;
- Planning for increased involvement of child welfare, child protection, and other social service agencies;
- Expanded chemical dependency treatment capacity, both for those involved in methamphetamine labs who are not sentenced to jail or prison, and for addicted offenders following their release from prison.

The Governor's Methamphetamine Coordinating Council has played an important role in ensuring cross-system collaboration, reaching across law enforcement, public health, prevention, and treatment fields.

The methamphetamine epidemic presents new challenges for targeted prevention activities. The information on child abuse and neglect specific to parents and caregivers who are abusing or are addicted to methamphetamine is limited and anecdotal. What is known, however, is that most studies report that between one-third and two-thirds of substantiated child abuse and neglect reports involve substance abuse including alcohol and other drugs.[8]

Treatment works. Health care costs declined, and employment and earnings increased following treatment. A 2000 study of adults who received inpatient chemical dependency treatment demonstrated a 91% drop in days involving amphetamine (including methamphetamine) use in the 30 days prior to the six-month follow-up.[9]

But resources are inadequate to meet current needs for treatment, no less those that can be projected in the course of the epidemic. Currently, it is estimated that 70% of offenders in prison are substance abusers, and it is likely that an increasing proportion of these will be methamphetamine addicts. Of those offenders who receive prison-based treatment, only 20% continue to receive treatment in the community after they are released. According to the Department of Corrections (DOC), there are 205 inmates released each month who have received prison-based treatment, but for whom DOC has no resources to assure continuing community-based treatment.

Without such treatment upon release, it is likely that many offenders will relapse and re-offend, adding still further to the methamphetamine problem.

In Washington State 6,223 adults and youth with primary amphetamine/methamphetamine addiction were admitted to publicly funded treatment in State Fiscal Year 2001, but DASA-funded treatment currently is only available to a small percentage of those who need it. Without treatment, those who are not imprisoned as a result of methamphetamine involvement may simply continue their involvement at new locations and impact still more communities. Heightened risks for child abuse, domestic violence, and the transmission of blood-infections will remain. Without treatment, family reunification efforts will be impossible, with resulting higher social welfare costs.

The methamphetamine epidemic can be stemmed, but it will necessitate the development of new partnerships, collaboration, and increased commitment from policymakers to address the epidemic's complexities. A multi-faceted approach holds out the promise of improving the health, safety, and welfare of Washington communities.

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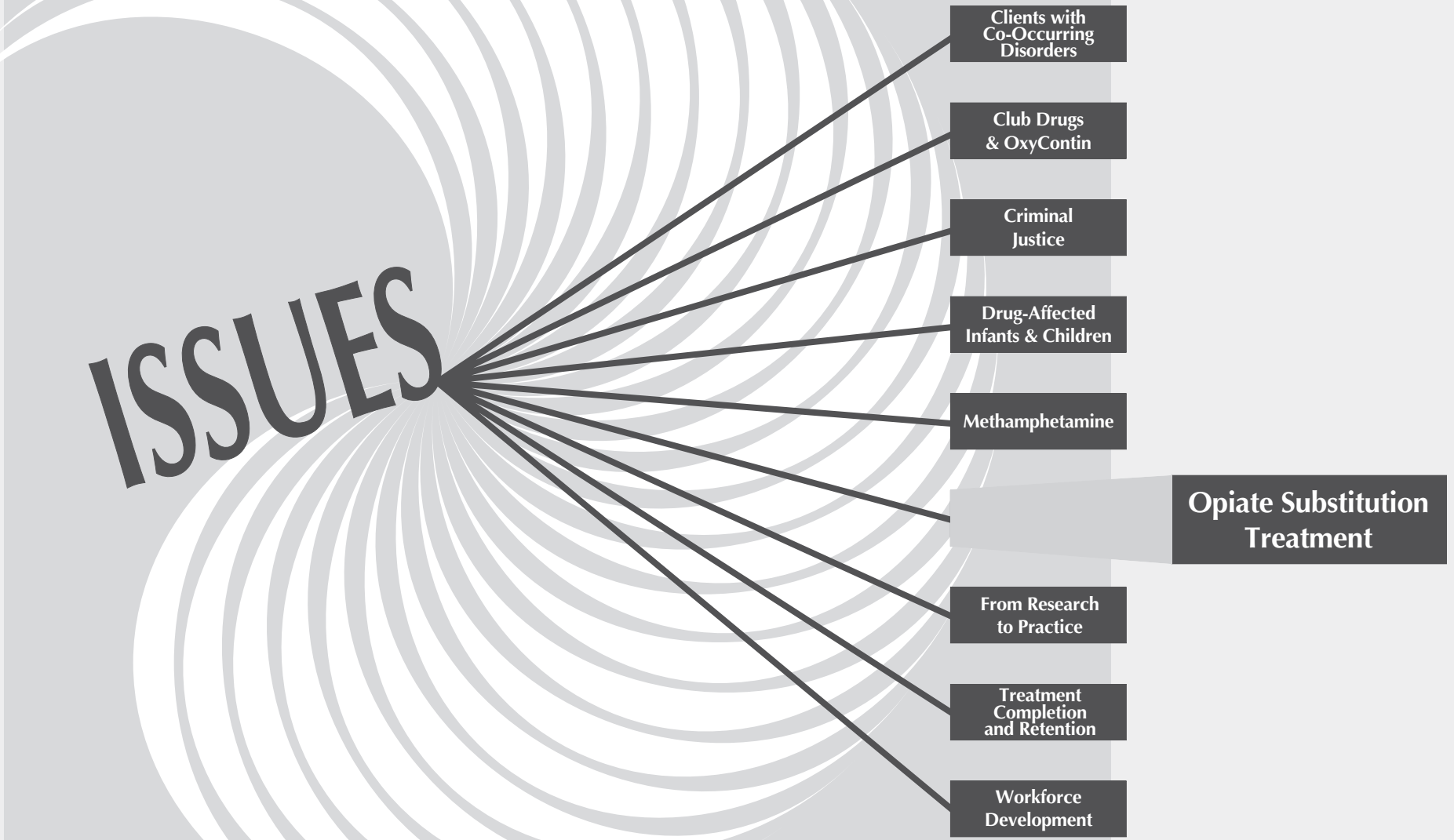


OPIATE SUBSTITUTION TREATMENT

The Office of National Drug Control Policy estimates there may be as many as 980,000 users of heroin nationwide.[1] It is estimated that approximately 29,000 Washington State residents have been dependent upon opiates (primarily heroin) during their lifetimes.[2] Most do not receive treatment. The National Institutes of Health estimate the financial costs of untreated heroin addiction to individuals, families, and society in the U.S. at approximately $20 billion each year.[3]

Chronic heroin addicts pose a significant public health risk to our communities. As a large majority are injection drug users (IDUs), heroin addicts are more likely to contract and spread HIV and hepatitis B and C. The federal Centers for Disease Control and Prevention estimate that IDUs (most of whom are heroin users), their sexual partners, and their offspring account for approximately 35% of new HIV infections each year.[4] Chronic heroin users are more likely to engage in criminal activity, and are more likely to place increased strain upon public resources in welfare costs, emergency room and hospital admissions, and psychiatric hospitalization. The rate of heroin-related deaths in King County grew more than 170% from 1990 to 1998, and the County now ranks third in the nation for both heroin use and overdoses. In 1998, there were more unintentional opiate overdose deaths in King County (140) than traffic fatalities (119).[5]

It should be noted, however, that heroin-related deaths in King County have declined approximately 30% since 1998, to 99 in 2000. Emergency room mentions of heroin/morphine have similarly declined. This is at least partially due to public health measures adopted by city and county government to address heroin addiction. King County authorized a 50% expansion in the number of opiate substitution treatment slots, and authorized a mobile methadone clinic. The number of chemical dependency treatment admissions for heroin increased from 1,140 in 1998 to 2,101 in 2000.

Scientifically Proven

Methadone and other forms of opiate substitution have been shown scientifically to work effectively in the treatment of heroin addiction. In its 2000 National Drug Control Strategy, the White House Office of National Drug Control Policy called methadone therapy "one of the longest established, most thoroughly evaluated forms of drug treatment."[6] A Consensus Panel convened by the National Institutes of Health (NIH) in 1997 concluded, "Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity." The 12-member panel strongly recommended broader access to methadone maintenance treatment programs for people addicted to opiates, and that federal and state regulations and other barriers impeding this access be eliminated. A 1998 review by the General Accounting Office found that methadone therapy helps keep more than 179,000 addicts off heroin, off welfare, and on the tax rolls as law abiding, productive citizens.[7]

Opiate substitution treatment clinics have been operating in Washington State for more than 25 years. As of December 2001, there are 11 opiate substitution treatment clinics operating in four counties in Washington State. Six fixed locations and one mobile clinic are in King County, two of which serve only private-pay patients. In addition, there is a pilot program at Harborview Medical Center through which physicians provide opiate substitution treatment to clinically stable patients. Pierce County has two clinics, and Spokane and Yakima Counties each have one. Clark County contracts with an opiate substitution treatment program in Portland, Oregon to serve its residents. As of January 1, 2001, 2,951 individuals were receiving opiate substitution treatment for heroin addiction. Of these, 1,865 (63.2%) were publicly funded. There are waiting lists, sometimes longer than six months, for the publicly funded slots at each of the operating

clinics, postponing treatment at that critical juncture when addicted individuals are prepared to access it. In addition, people with chronic heroin addiction living in rural and even some urban areas have to travel six days a week to King, Pierce, Yakima, or Spokane Counties or to Portland to access treatment. . In King County, it is estimated that there are between 15,000-20,000 injection drug users, 70% of whom are chronic heroin users and could benefit from treatment.

In SFY 2001, 4,776 individuals in Washington State received opiate substitution treatment; 2,870 of these patients received treatment funded through the Division of Alcohol and Substance Abuse (DASA), at a cost of $4.78 million.

Evaluating Cost-Effectiveness and Efficacy

SSB 5417 [now RCW 7096A.420(4)] requires DASA to provide an "outcome analysis" of programs providing opiate substitution treatment. In fact, DASA has been studying opiate substitution treatment for several years and has established appropriate performance measures for evaluating cost effectiveness and efficacy. In doing so, it has contracted with the University of Washington Alcohol and Drug Abuse Institute to undertake a management study to answer two questions:

- Does opiate substitution treatment contribute to reducing the negative consequences of opiate addiction – crime, health problems, and reliance on welfare?
- Does opiate substitution treatment support the Department of Social and Health Services' mission to assist clients in maintaining safe, secure, self-sufficient, and healthy lives?

The results of the 2001 study are compelling. In a sample of 726 publicly funded clients discharged from treatment, the following outcomes were achieved:

- Property crimes were reduced by 56%;
- Emergency room visits decreased by 58%;
- Overall arrest rates declined by 43%;
- Drug offense arrests dropped by 52%;
- Medical hospital admissions were reduced by 55%;
- Utilization of major health care services were lowered by 46%;
- Psychiatric hospitalization declined by 25%.

Rates of change for those in treatment for more than a year were even greater. Especially striking was reduction in crime for those involved in treatment for one year or more. The percentage of patients arrested (both publicly funded and private-pay) declined from 30% in the year prior to treatment to 10% during treatment prior to discharge, a 67% reduction. (Average length of treatment for those in treatment longer than one year was 956 days – almost three years – for publicly funded patients, and 979 days for private-pay patients.) Arrest rates are likely even lower among patients who remain in treatment over the longer term. Typical clients were white, almost 40 years old, and were parents with children. Treatment has been shown to have a stabilizing effect on clients, and helpful in moving clients off of welfare and toward self-sufficiency.[8]

Treatment Works

At admission for opiate substitution treatment, 86% of publicly funded clients used heroin at least daily. By discharge, only 19% were daily users, representing a decline of 78%. Required urine samples from all opiate substitution patients taken in 2000 were analyzed by Comprehensive Toxicology Services to see whether there were reductions in illicit drug

use. Of 19,711 urine specimens that tested positive for methadone, only 1,929 (9.8%) were positive for other drugs. It should be noted that patients are required to provide more specimens in the early stages of the program, when they are less likely to be stabilized and drug-free. While it is often true that opiate substitution treatment does not result in total abstinence from opiates by all clients, it clearly facilitates substantial reductions in the frequency and likelihood of heroin use.

Challenges Ahead

In recognition of the success of opiate substitution treatment in improving public health and safety, in 2001 the Washington State Legislature passed Substitute Senate Bill 5417. Under the new statute, county legislative authorities can no longer prohibit opiate substitution treatment programs in their jurisdiction. Instead, upon receiving an application for certification of an opiate substitution treatment program, DASA is required to consult with county and city legislative authorities, demonstrate a need in the community for such a program, and certify only as many program slots as can be justified by the need. Two public hearings must be held, and programs must be sited in accordance with appropriate county or city land use ordinances. Counties now have the authority to lift the lid of 350 participants per program. Plans are moving ahead in Thurston County to open a new opiate substitution treatment program. In addition, preliminary interest in opening new programs has been expressed in Clark, Cowlitz, and Snohomish Counties.

The NIH Consensus Panel laid out four challenges for the future of opiate substitution programs:

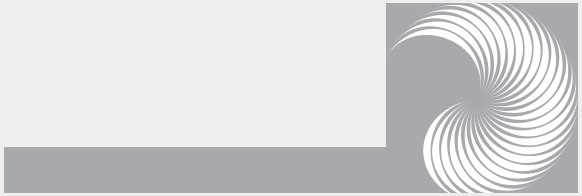
- Making treatment as cost-effective as possible while maintaining or improving quality of care.
- Increasing the availability and variety of treatment services.
- Including and ensuring wide participation by physicians trained in substance abuse to oversee medical care.
- Providing additional funding for opiate addiction treatment and coordinating these services with other necessary social services and medical care.

The Panel also recommended that opiate-dependent individuals under legal supervision – probation, parole, in jails and prisons – should have access to methadone treatment, and called on the White House Office of National Drug Control Policy and the U.S. Department of Justice to take the necessary steps to implement this recommendation. Finally, the Panel noted that stigmas about addiction and methadone are barriers to expanding treatment, and that leadership from policymakers and the medical community are needed to educate the public.

New Developments

Several recently adopted and proposed regulatory and legislative developments in both regulation of opiate substitution treatment programs and in the use of new medications will impact our ability to meet these challenges. These will require attention from DASA, the medical community, and local providers to ensure more clients can gain access to cost-effective, quality services.

New federal regulations transfer regulatory authority for opiate substitution treatment programs from the U.S. Food and Drug Administration (FDA) to the Center for Substance Abuse Treatment (CSAT). Federally approved accreditation bodies such as the Rehabilitation Accreditation Commission (CARF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will now conduct program audits in lieu of federal auditors. In 2001, DASA applied for and was approved as an opiate substitution treatment program accreditation body, the only state alcohol and drug abuse agency in the United States to receive such recognition.



As part of a federal experiment, several states have implemented physician-based opiate substitution treatment programs on a limited basis, and draft federal guidelines have been distributed for review. Federal and state statutes and regulations will need to be revised and implemented before the programs can be fully established. Such programs may be most appropriate for stable, long-term patients who no longer require extensive monitoring and intensive counseling services. The transfer of long-term, stable patients to physician-based programs would, in turn, free up badly needed resources and treatment slots in opiate substitution clinics.

Such a program is currently being piloted between Evergreen Treatment Services (ETS) and Harborview Medical Center, and shows great sign of promise. Beginning in January 2000, 30 patients who were clinically stable for at least one year were transferred to Harborview (10 in January, and the rest during the summer of 2000). They had each been receiving opiate substitution treatment for between two and 22 years, with a mean of ten years. Of these patients, 27 currently remain in the program after a year or more; one transferred to an opiate substitution treatment program in another state; one transferred back to the ETS mobile van program; and one died (cause of death was unrelated to drug use.) None was discharged from treatment because of rule violations related to drug use.

A final challenge is finding ways to reduce demand for methadone maintenance treatment by intervening in the lives of patients before such treatment is needed. Opiate substitution treatment is for patients whose addiction has already become chronic. Earlier intervention with a full range of treatment and the use of newer and promising medications such as naltrexone and buprenorphine may prevent the need for opiate substitution and contribute to ensuring healthier individuals and healthier communities.

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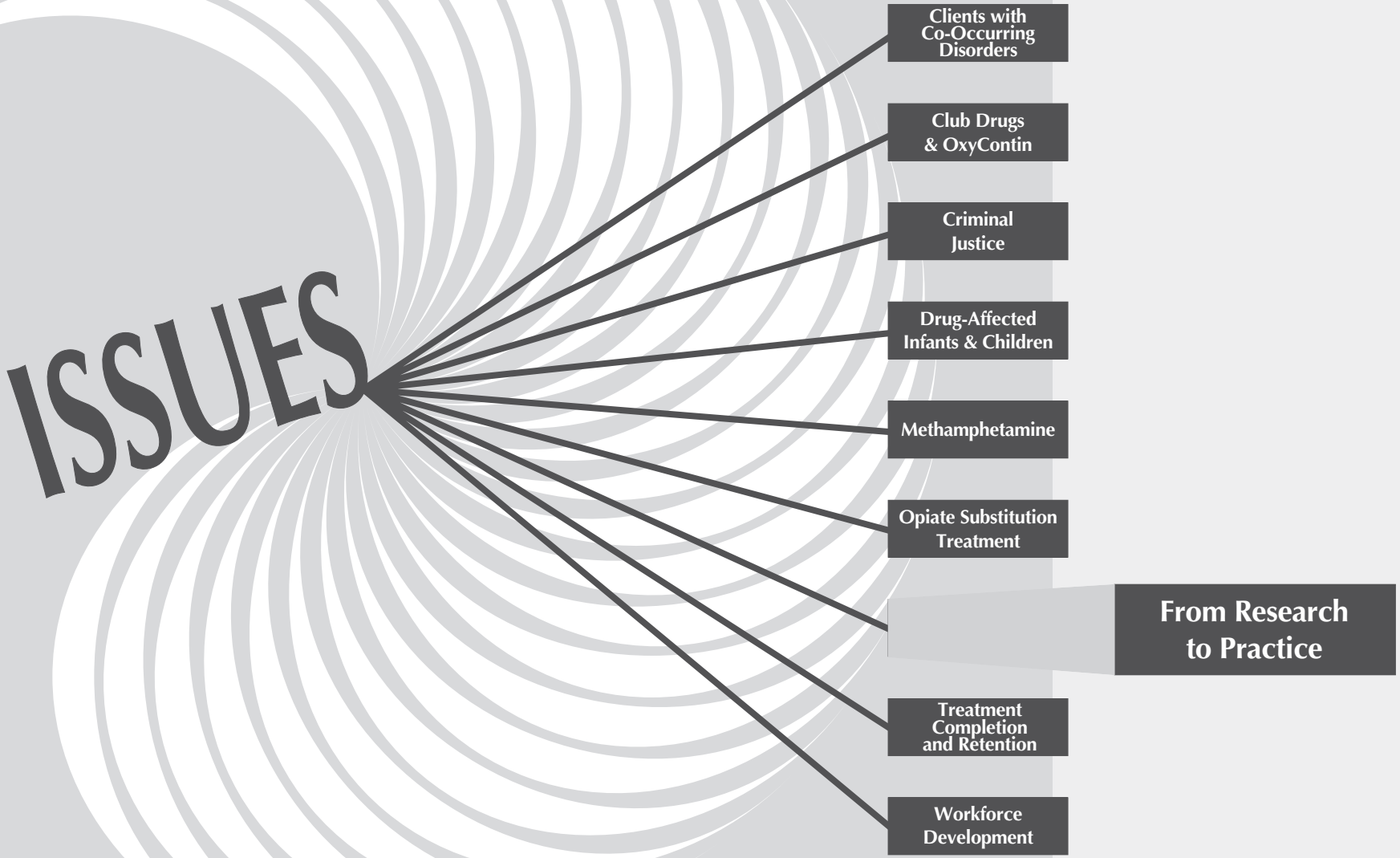


From Research to Practice Clinical Trials Network

There is a growing movement, both nationally and within Washington State, to integrate substance abuse research, policy, and clinical practice. A significant impetus for this movement came from a 1998 Institute of Medicine report entitled *Bridging the Gap Between Practice and Research. Forging Partnerships with Community-Based Drug and Alcohol Treatment*[1]. This report documented the growing isolation between clinical-provider and research communities. Its authors argued that this widening gap between research and clinical practice is one of the major threats to the survival of the chemical dependency treatment system. It made a number of recommendations directed at facilitating partnerships between practice, research, and policy.

Statewide Bridging the Gaps Workgroup

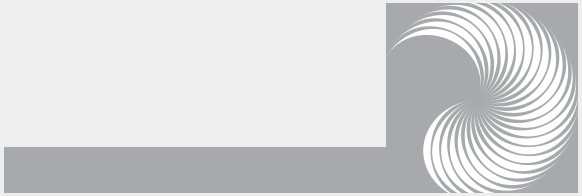
In response to the Institute of Medicine report, the Division of Alcohol and Substance Abuse (DASA) formed a statewide Bridging the Gaps Workgroup in 1999 to begin the work of forging partnerships with treatment providers, providers of prevention services, researchers, and policymakers within Washington State. This workgroup currently includes about 50 members. Membership on the Statewide Bridging the Gaps Workgroup is open to interested persons who represent the research, practice, policy, or client advocacy communities.

The workgroup has had a number of achievements, including planning two statewide research conferences that blended research, practice, and policy, as well as preparing the groundwork for Washington State to become a "node" in the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN). The workgroup currently meets about three times a year and continues to provide an opportunity for exchange among researchers, providers, and policymakers on issues of mutual interest. A current goal of the workgroup is to lay the groundwork necessary for Washington State to successfully compete for a Treatment Improvement Collaborative grant from the federal Center for Substance Abuse Treatment. This grant would allow significant expansion of current collaborations among the research, practice, and policy communities within Washington State.

Washington State Node of the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN)

In January, 1999, NIDA announced the formation of the Clinical Trials Network (CTN) in response to the 1998 Institute of Medicine report. The structure of the CTN is similar to clinical trial projects on AIDS, cancer, and other medical research challenges undertaken by the National Institutes of Health. The ultimate goal of CTN is to have multiple regional "nodes" around the United States, with at least 10 community treatment programs (CTP's) affiliated with each node. Each node will participate in the development, implementation, and evaluation of behavioral and pharmacological therapies targeted at treatment as delivered in the real world settings of the affiliated CTP's. The purpose is to take new treatments that have been shown to be effective in specialized treatment research settings with restricted patient populations, and apply these treatments on a wide-scale basis in practice settings.

The Washington State Node is one of 14 nodes currently within the national CTN. It is based at the University of Washington Alcohol and Drug Abuse Institute (ADAI), and has eight community-based treatment programs (CTP's) as full collaborators. Washington State CTP's include Evergreen Treatment Services, Seattle; Residence XII, Bothell; Recovery Centers of King County, Kent; Kitsap Recovery Center, Bremerton; Evergreen Manor, Everett; Providence Behavioral Health Services, Everett; Vancouver Division of Portland Veteran's Administration Medical Center, Vancouver; Triumph Treatment Services, Yakima. Dennis Donovan,



Ph.D., serves as the Principal Investigator of the Washington State Node.

At the present time, the Washington State Node is participating in one national CTN protocol on buprenorphine as a detoxification medication for the treatment of opiate abuse and dependence. This trial is being conducted at Providence Behavioral Health Services, Everett, and is designed to determine the relative advantages of three rates (7 days versus 30 days versus 60 days) of buprenorphine-naloxone (BUP/NX) detoxification following four weeks of BUP/NX flexible dosing stabilization.

For more information about the Bridging the Gaps Workgroup or the Washington State Clinical Trials Network, contact the Research and Evaluation Section at DASA.

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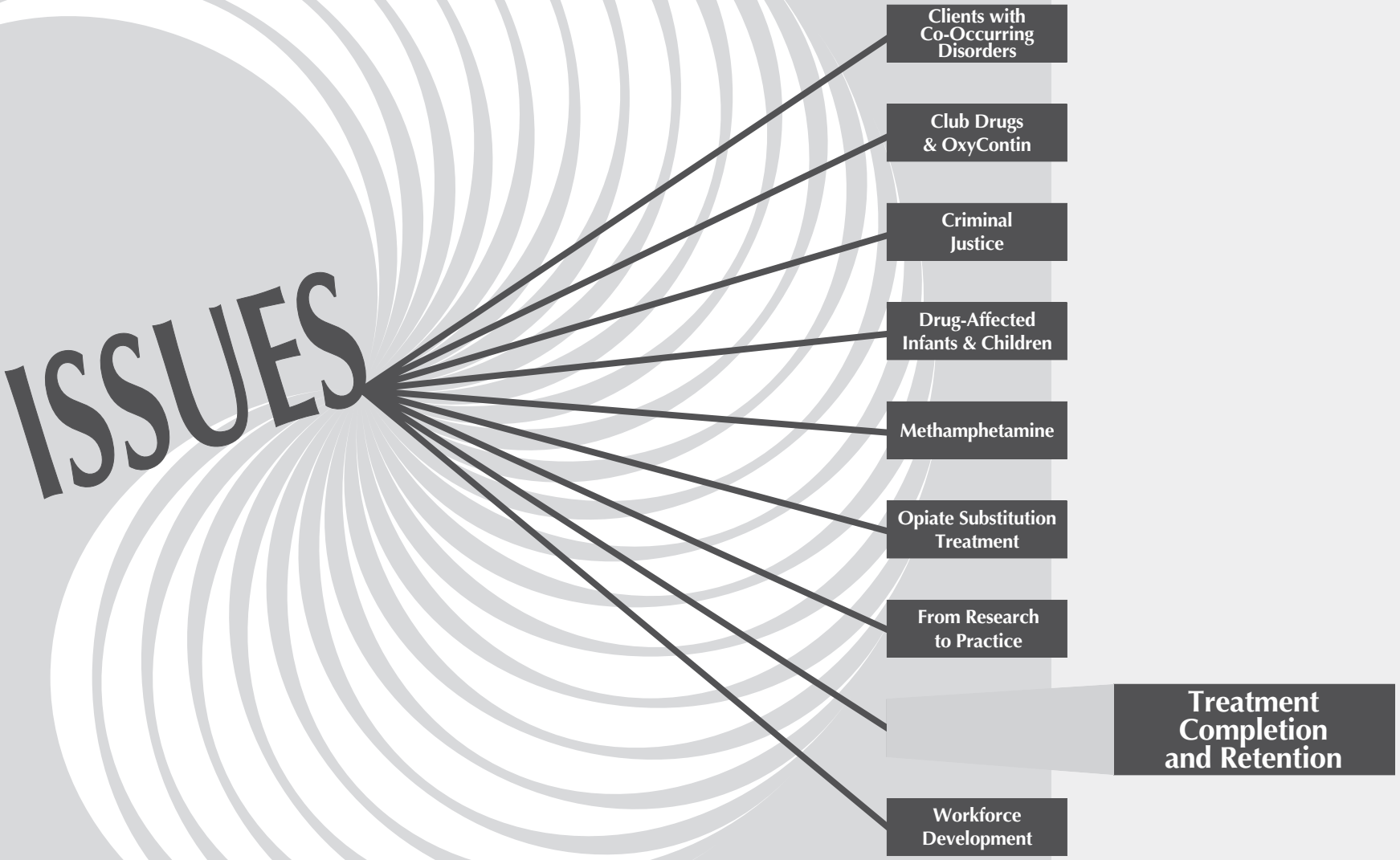


Treatment Completion and Retention

As part of its Accountability Scorecard with the Governor, the Department of Social and Health Services has pledged to ensure better outcomes for residents it serves and, in doing so, help build safer and healthier communities. As part of this commitment, the Division of Alcohol and Substance Abuse (DASA) has pledged to improve completion and retention rates for publicly funded patients receiving chemical dependency treatment.

This choice of strategic focus is soundly based in the science of treatment. Research has consistently indicated that patients who complete treatment experience more favorable outcomes than those who do not. They are more likely to remain abstinent, have lower medical care utilization, have fewer requirements for psychiatric care, are less likely to commit crimes, are more likely to become employed, and have higher post-treatment wages. Pregnant women who complete treatment are more likely to have full-term deliveries, babies with higher birth weights, and experience fewer fetal or infant deaths. These trends hold true regardless of whether patients are adolescents or adults. While admission to treatment itself has been demonstrated to deliver these same effects, treatment retention and completion further enhance improved outcomes.

To represent its commitment to improved patient outcomes and safer and healthier communities, DASA has pledged that by July 2003, 76% of adults and 62% of youth will complete residential treatment. To accomplish this goal, DAS has assembled an internal working group, with representatives from its treatment, research, certification, research, and planning and policy sections, as well as regional administrators, to spearhead this effort. DASA is also working closely with provider advisory groups to implement this objective.

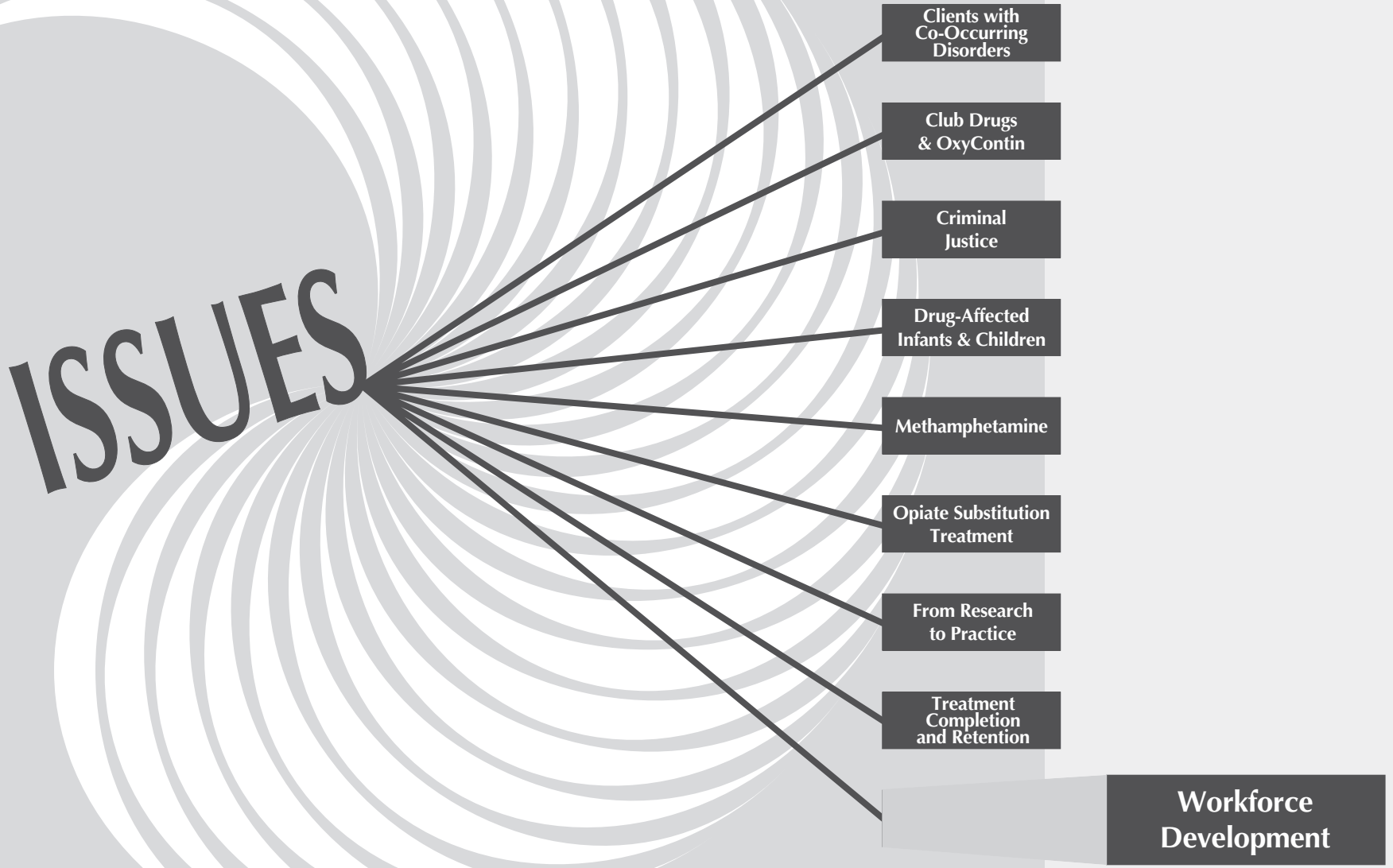
With the assistance of representatives from counties, tribes, and residential and outpatient providers, DASA reviewed definitions of discharge types and incorporated them into the data dictionary of the new TARGET 2000 system. Language was then developed for use in contracts with residential providers, with the expectation that requirements will soon be extended to outpatient providers as well.

DASA is quite aware that the patient mix at every treatment facility is different, and so while it is expected that treatment retention/completion rates can improve at every agency, no across-the-board target can be reasonably applied. With this in mind, DASA Research and Evaluation Section is working with treatment program managers to understand and evaluate the usefulness of "case mix adjustment" in helping agencies set reasonable targets for treatment completion.

Training will be a key element to fulfilling DASA's commitment. Dissemination of best practices within all treatment agencies as well as the integration of all components of treatment and aftercare will be necessary to effect positive change. The Treatment Completion Workgroup will be working with the statewide "Bridging the Gaps" Workgroup to develop a list of science-based practices that have been shown to enhance treatment completion.

Between July-November 2001, completion rates for adults (76%) and youth (62%) in residential treatment already met or exceeded statewide goals. However, it is fully expected that sustained commitment in this area will result in even better patient outcomes, and improve the health, safety, and vitality of Washington's diverse communities.

The Future: Policy Issues Confronting Washington State



Workforce Development Issues For Treatment and Prevention Professionals

How does a workforce of several thousand people spread out over the geographic expanse of Washington State stay skilled in delivery of the latest research-based chemical dependency treatment? How does this workforce stay abreast of rapidly evolving best practices in prevention? Moreover, what will attract new people into a field usually considered underpaid and under-appreciated?

The Division of Alcohol and Substance Abuse (DASA) takes these issues very seriously. In cooperation with other federal and state agencies, colleges and universities, professionals in the field, and other interested parties, DASA is addressing these issues in both the treatment and prevention fields.

Chemical Dependency Treatment

Effective chemical dependency treatment requires knowledgeable and skilled treatment professionals equipped to provide quality care for their patients. Unfortunately, service provider agencies report increasing difficulties in recruiting and retaining qualified and trained chemical dependency professionals (CDPs).

One reason for the shortage of professionals may be that salaries are not keeping pace with new education and proficiency requirements. Recently expanded education requirements, without similar increases in compensation, may be causing potential entrants to the field to choose other career paths.

A counselor survey was conducted to assess the actual salaries paid within various treatment settings. The results of that survey were published in 2001 in a report title *Salaries of Chemical Dependency Counselors in Washington State: Findings from a Pilot Survey.* Salaries varied according to degree of responsibility with the highest level associated with clinical supervisors, the intermediate level with counselors, and the lowest level with interns. Median annual salary for a CDP was $29,848.

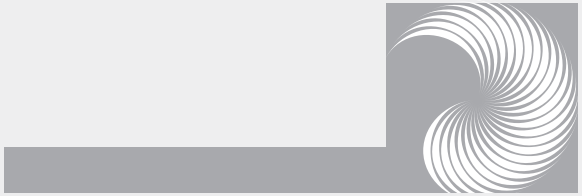
In collaboration with interested colleges and providers, DASA has formed a Counselor Shortage Committee. Two main goals of the Committee are: 1) To determine barriers that may be affecting recruitment and retention; and, 2) To develop a strategy to increase the candidate pool of CDPs statewide. In 2002, the Committee will be examining the Washington statute defining CDP requirements and will recommendations for amendments.

The Committee has also been working more directly on recruiting and retaining CDP's. More than 25,000 copies of a new brochure entitled "Why YOU Should You Become a Chemical Dependency Counselor" have been distributed through chemical dependency providers, colleges, vocational schools, state agencies, and the Washington State Alcohol and Drug Clearinghouse.

DASA enlisted the Alcohol/Drug Help Line to design a website for chemical dependency positions around the state. Iindividuals can now review position announcements and submit their resumes free of charge. This website is linked with Department of Health, colleges, universities, tuition waiver information, and the current Revised Code of Washington (RCW) and Washington Administrative Codes (WAC) related to certification.

DASA continues to facilitate discussions with community colleges – a staple in providing required education classes for prospective counselors – to identify and address educational barriers. Representatives from DASA, colleges, universities, and other training institutions are developing consistency between the state's various chemical dependency education programs. This will allow students more latitude to transfer between schools, especially when required internships are not available in their geographic areas.

DASA supports and manages a tuition waiver program for low-income individuals studying to become certified chemi-



cal dependency professionals at state colleges and universities. Historically, the program has targeted ethnic minorities and persons with disabilities interested in entering the field.

DASA and the committee are also helping develop regional solutions through work with the Northwest Frontier Addiction Technology Transfer Center (NFATTC). A survey of counselors for the Pacific Northwest states of Alaska, Idaho, Oregon, and Washington conducted for NFATTC found that 71% of chemical dependency counselors hold a Bachelor of Arts degree or better, and 70% have completed specialized educational coursework in substance abuse treatment. About 87% of Washington respondents have completed specialized education compared with 60-63% for the other three states. The report, *"Substance Abuse Treatment Workforce Survey, A Regional Needs Assessment,"* was prepared for NFATTC by RMC Research Corporation.

Substance Abuse Prevention

Though newer and less defined than the chemical dependency treatment field, workforce development issues for substance abuse prevention providers are every bit as pressing. In 1998, DASA and the Prevention Subcommittee of the Association of County Human Services sponsored a study "Washington Prevention Professionals: A Profile" that detailed serious concerns related to the field. There is no set collegiate course of study in prevention in Washington State. Most prevention professionals come to the field as second or even third careers. They often do not possess basic information related to theories of prevention, pharmacology, or substance abuse, or the skill set associated with effective performance. Prevention professionals operate very independently from their sponsoring organizations and, in many cases, with limited supervision.

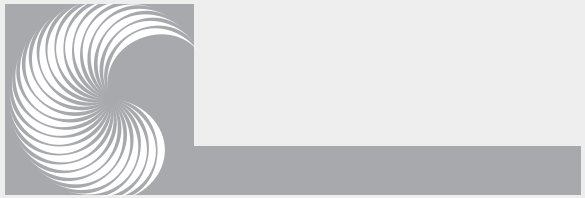
The study indicated that salaries for most prevention professionals are relatively low, averaging just over $25,000 per year. Many prevention professionals leave the field for economic reasons. At the same time, the study indicated that prevention professionals report very high job satisfaction.

As prevention is a rapidly evolving field, new research finding regarding effective approaches are being published all the time. This presents a serious challenge in trying to ensure prevention professionals are equipped with the best information and skills necessary to do the best possible job.

In collaboration with its prevention providers and partners, DASA is implementing a two-year training development plan. The plan features at its core a weeklong, intensive orientation course called Substance Abuse Prevention Specialist Training (SAPST) developed by the Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies (Western CAPT). The plan calls for offering the course a minimum of six times during the current biennium. In addition, DASA will conduct training-of-trainers workshops twice each year to build training capacity and expand the number of trained prevention providers. DASA is also participating with Western CAPT in the development and design of an advanced training that would focus on developing specific skills needed by prevention professionals.

DASA has been involved in several other key efforts to elevate the professional status of prevention professionals. The first was a comprehensive study of prevention professionals in Washington State that identified and listed the key job activities and tasks they perform. That document, *"A Skill Standard for Substance Abuse and Violence Prevention Professionals,"* was re-published in 2001 and widely distributed.

The second initiative is to actively encourage qualified prevention professionals to seek certification from a national certification body. There presently is no certification requirement in Washington, but Washington State prevention pro-



fessionals can obtain certification through other states' certification boards. There is local interest in establishing and maintaining a Washington board.

Finally, DASA has been coordinating with community colleges and universities to expand the quantity and quality of prevention classes. So far, at least two new schools will be offering prevention classes in 2002, one of them being an Internet-based, online course that can be taken anywhere in the state.

Data Sources

Data Sources

Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State – 2002 Report contains information and data from a variety of federal and state government agencies. Given the diverse indicators included in this Report, data sources differ significantly with regards to methodology, sampling and collection procedures, as well as reliability and validity of the data. Readers are encouraged to consult the original data sources for more detailed information. Additional organizations are presented to provide the reader with a variety of other resources. When available, websites are provided.

National Sources

Monitoring the Future (http://www.isr.umich.edu/src/mtf/)

The Monitoring the Future study is conducted by the Institute for Social Research, University of Michigan and supported by research grants from the National Institute on Drug Abuse. The Monitoring the Future project, begun in 1975, has many purposes. Among them is to study changes in the beliefs, attitudes, and behavior of young people in the United States. Changes in public attitudes and behavior are often first seen among youth. The results of the study are useful to policy makers at all levels of government. Data are used to monitor progress toward Goal 7 (Safe, Disciplined, and Alcohol and Drug-Free Schools) of the Goals 2000 National Education Goals, as well as toward national health objectives. Study results are also used to monitor trends in substance use and abuse among adolescents and your adults, and are used in the development of the White House National Drug Control Strategy.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) (http://www.niaaa.nih.gov/)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems. NIAAA also provides leadership in the national effort to reduce the severe and often fatal consequences of these problems by:

- Conducting and supporting research directed at determining the causes of alcoholism, discovering how alcohol damages the organs of the body, and developing prevention and treatment strategies for application in the health care system;
- Supporting and conducting research across a wide range of scientific areas including genetics, neurosciences, medical consequences, medication development, prevention, and treatment through the award of grants and within the NIAAA's intramural research program;
- Conducting policy studies that have broad implications for alcohol problem prevention, treatment, and rehabilitation activities;
- Conducting epidemiological studies such as national and community surveys to assess risks for and magnitude of alcohol-related problems among various population groups;
- Collaborating with other research institutes and federal programs relevant to alcohol abuse and alcoholism, and providing coordination for federal alcohol abuse and alcoholism research activities;

Data Sources

- Maintaining continuing relationships with institutions and professional associations; with international, national, state and local officials; and voluntary agencies and organizations engaged in alcohol-related work; and
- Disseminating research findings to health care providers, researchers, policymakers, and the public.

NIAAA is one of 19 institutes that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the federal government. NIH is a component of the Public Health Service within the U.S. Department of Health and Human Services.

Bureau of Justice Statistics (http://www.ojp.usdoj.gov/bjs/)

The Bureau of Justice Statistics (BJS), a component of the Office of Justice Programs in the U.S. Department of Justice, is the United States' primary source for criminal justice statistics. BJS collects, analyzes, publishes, and disseminates information on crime, criminal offenders, victims of crime, and the operation of justice systems at all levels of government. These data are critical to federal, state, and local policymakers in combating crime and ensuring that justice is both efficient and evenhanded.

Annually, BJS publishes a document that presents findings of major BJS statistical series, describes BJS data collection programs, and summarizes programs to help States and localities to develop automated information systems. The most recent edition is *Bureau of Justice Statistics 2000: At a Glance*. The information in this report is also available from the BJS web site at http://www.ojp.usdoj.gov/bjs/abstract/bjas00.htm.

Federal Bureau of Investigation – Uniform Crime Reports (http://www.fbi/ucr/ucr.htm)

The Federal Bureau of Investigation's (FBI) Uniform Crime Reporting Program (UCR) collects crime statistics from alomst 17,000 state and local law enforcement agencies, covering almost 95% of the nation's population. Data are gathered by state and local agencies and submitted to the FBI, in most cases through state UCR offices. Reliability and completeness of data are the responsibility of the submitting agencies. The FBI monitors each submitted report, and significant increases or decreases in rates are subject to special inquiry by UCR staff.

The primary limitation of UCR is that it measures reported crime rather than all crimes committed. Reporting levels may vary according to a wide variety of factors, including community, funding, and aggressiveness of local law enforcement agencies. Another system, the National Crime Victimization Survey, collects data on unreported as well as reported crime by surveying a representative sample of households.

In Washington State, UCR reports produced by the Washington Association of Sheriffs and Police Chiefs and which is the source for FBI state data, do not include data from the Seattle Police Department (SPD). SPD does not collect their statistics in a manner that is compatible with UCR. Crime indicators in this *Report* do not include data from Seattle.

Data Sources

Centers for Disease Control and Prevention (http://www.cdc.gov/)

The federal Centers for Disease Control and Prevention (CDC) is recognized as the lead federal agency for protecting the health and safety of Americans, for providing credible information to enhance health decisions, and for promoting health through strong partnerships. Headquartered in Atlanta, CDC serves as the national focus for developing and applying disease prevention and control strategies, environmental health approaches, and health promotion and education activities. There are 11 national centers. CDC is one of eight federal public health agencies within the U.S. Department of Health and Human Services.

National Center for Injury Prevention and Control (http://www.cdc.gov/ncipc/index.htm)

The National Center for Injury Prevention and Control works to reduce morbidity, disability, mortality, and costs associated with injuries.

HIV/AIDS Surveillance Report (http://www.cdc.gov/hiv/stats/hasrlink.htm)

The HIV/AIDS Surveillance Report is published semi-annually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention. It contains tabular and graphic information about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, sex, race/ethnicity, age group, vital status, and case definition category.

National Center for HIV, STD and TB Prevention – Division of Sexually Transmitted Diseases (http://www.cdc.gov/nchstp/dstd/Stats_Trends/Stats_and_Trends.htm)

The Division of STD Prevention at the Centers for Disease Control and Prevention provides national leadership through research, policy development, and support of effective services to prevent sexually transmitted diseases (including HIV infection) and their complications such as enhanced HIV transmission, infertility, adverse outcomes of pregnancy, and reproductive tract cancer. The Division assists health departments, health-care providers, and non-governmental organizations and collaborates with other governmental entities through the development, syntheses, translation, and dissemination of timely, science-based information; the development of national goals and science-based policy; and the development and support of science-based programs that meet the needs of communities.

National Center for HIV, STD and TB Prevention – Division of Tuberculosis Elimination (http://www.cdc.gov/nchstp/tb/surv/surv.htm)

The TB Surveillance Reports are published annually by the Division of TB Elimination, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention. They contain tabular and graphic information about reported TB cases collected from 59 reporting areas (the 50 states, the District of Columbia, New York City, U.S. dependencies and possessions, and independent nations in free association with the United States). The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistics areas with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, drug resistance, etc).

Data Sources

Behavioral Risk Factor Surveillance System (http://www.cdc.gov/nccdphp/brfss/)

The Behavioral Risk Factor Surveillance System (BRFSS), administered and supported by the Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, is an on-going data collection program. By the early 1980s, scientific research clearly showed that personal health behaviors played a major role in premature morbidity and mortality. Although national estimates of health risk behaviors among U.S. adult populations had been periodically obtained through surveys conducted by the National Center for Health Statistics, these data were not available on a state-specific basis. This deficiency was viewed as critical for state health agencies that have the primary role of targeting resources to reduce behavioral risks and their consequent morbidity. National data may not be appropriate for any given state; however, state and local agency participation is critical to achieving national health objectives.

About the same time as personal health behaviors received wider recognition in relation to chronic disease morbidity and morality, telephone surveys emerged as an acceptable method for determining the prevalence of many health-risk behaviors among populations. In addition to cost advantages, telephone surveys were specially desirable at the state and local level, where the necessary expertise and resources for conducting area probability sampling for in-person household interviews were not likely to be available.

As a result, surveys were developed and conducted to monitor state-level prevalence of the major behavioral risks among adults associated with premature morbidity and mortality. The basic philosophy was to collect data on actual behaviors, rather than on attitudes or knowledge, which would be especially useful for planning, initiating, supporting, and evaluating health promotion and disease prevention programs. Although the BRFSS was designed to collect state-level data, a number of states from the outset stratified their samples to allow them to estimate prevalence for regions within their respective states. By 1994, all states, the District of Columbia, and three territories were participating in the BRFSS.

National Center for Health Statistics (http://www.cdc.gov/nchs/)

The mission of the National Center for Health Statistics (NCHS) is to provide statistical information that will guide actions and policies to improve the health of the American people. As the nation's principal health statistics agency, NCHS is responsible for providing accurate, relevant, and timely data. Some NCHS data systems and surveys are ongoing annual systems while others are conducted periodically. NCHS has two major types of data systems: those based on populations, containing data collected through personal interviews of examinations; and those based on records, containing data collected from vital and medical records.

National Highway Traffic Safety Administration – Fatality Analysis Reporting System (http://www-fars.nhtsa.dot.gov)

The Fatality Analysis Reporting System (FARS) was developed in 1995 to facilitate collection and reporting of data for all fatal crashes involving automobiles in the United States, and to provide a basis for evaluating overall highway safety, motor vehicle safety standards, and highway safety initiatives and programs. FARS maintains cooperative agreements with agencies in each state to collect and report fatal crash data in a standard format. Each state in turn locates appropriate source documents from which fatal crash information is extracted.

Data Sources

State Sources

Washington State Department of Social and Health Services, Divisions of Alcohol and Substance Abuse - TARGET

TARGET (Treatment Assessment Report Generation Tool) is a reporting management information system used by the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Reporting is required for treatment agencies providing public sector-contracted/funded treatment services and optional for private pay individuals served. TARGET information collection is based on establishing a baseline at admission to treatment and capturing/identifying changes to that baseline upon discharge, thus providing information on progress during treatment.

Office of Financial Management – Population Trends for Washington State (http://www.ofm.wa.gov)

The Office of Financial management (OFM) provides official population counts and estimates. Population figures reported by OFM include all persons who normally reside in the state, including military personnel and dependants, persons in correctional institutions, residents of nursing care facilities, and college students.

Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, and Research and Data Analysis – Washington Needs Assessment Household Survey (http://psy.utmb.edu)

The Washington Needs Assessment Household Survey (WANAHS) was a statewide survey of over 7,000 adults designed to measure the prevalence of substance use and need for treatment. The survey was conducted over a 14-month period from September 1993 through October 1994. The WANAHS sample included large number of minorities and other groups in order to facilitate demographic analysis. Several statewide and county-level profiles have been prepared based on WANAHS, the most recent being *Profile of Substance Use and Need for Treatment in Washington State* (1999).

Washington State Department of Health – Center for Health Statistics (http://www.doh.wa.gov/)

Data used come from Certificates of Live Birth, Fetal Death, Death, Marriage, and Dissolution. Data for Washington State Vital Statistics are compiled for each year from certificates received before April 15 of the following year.

Washington State Department of Health, Office of Hospital and Patient Data System – Comprehensive Hospital Abstract Reporting System

The Washington State Department of Health's Comprehensive Abstract Reporting System (CHARS) monitors hospital admission trends, causes of hospitalization, and other indices used to evaluate the quality and accessibility of health care in Washington. Key data elements include patients' age, sex, physician, primary and secondary diagnoses, principal and secondary procedures, length of stay, and discharge status.

Data Sources

CHARS does not include data from federal, military and Veteran's Administration hospitals. Also excluded from the system are emergency room visits, data from outpatient facilities, surgery centers, birthing centers, and free-standing mental health, substance abuse, and rehabilitation centers or clinics.

Washington Traffic Safety Commission (http://www.wa.gov/wtsc/index.htm)

Collaboration among state, federal, and local partners is key in designing and implementing successful traffic safety programs. Each year the federal government allocates part of the federal Highway Trust Fund to the states to carry out highway safety programs. The Washington Traffic Safety Commission (WTSC) has administered these funds and facilitates these efforts in Washington State since 1967. Governor Gary Locke serves as WTSC chair. WTSC offers several programs, including the following: Impaired Driving, Community DUI & Traffic Safety Programs, Occupant Protection, Police, Traffic Records and Research, Youth, College-Age, Pedestrian/Bicycle, and Public Information and Education.

Washington State Survey of Adolescent Health Behaviors.

The Washington State Survey of Adolescent Health Behaviors (WSSAHB) provides information about the health attitudes and behaviors of Washington youth. A student survey has been conducted in Washington in even-numbered years since 1988, under the auspices of the Office of the Superintendent of Public Instruction (OSPI). The WSSAHB includes a sample of public schools students in grades 6, 8, 10, and 12. The survey provides information on tobacco, alcohol and other drug use, violence, related risk and protective factors, and demographics (age, race, and gender).

Survey samples are selected using a stratified cluster sampling procedure, with schools being the primary sampling unit. Data from student surveys are useful for obtaining statewide estimates of the prevalence of health risk behaviors among youth, examining trends and patterns in risk behaviors, and establishing profiles of persons at risk. Caveats related to the data include:

- Students survey does not represent youth who have dropped out of school. It is thought to be likely that these youth are the most likely to engage in high-risk behavior.
- Health risk behaviors may be underestimated as it is self-reported. Willingness to self-report behavior is subject to social acceptability norms.
- Changes in time of year for survey administration means that students may differ in age and experience from survey to survey, and seasonality factors may affect results. In such instances (as in 2000), data may not be comparable with previous surveys or with national surveys conducted at a different time of year.